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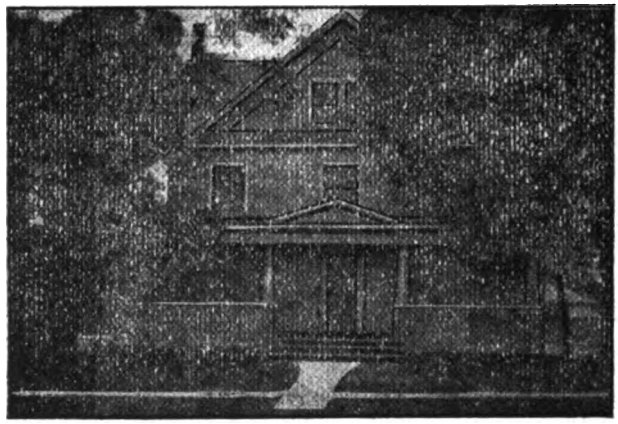

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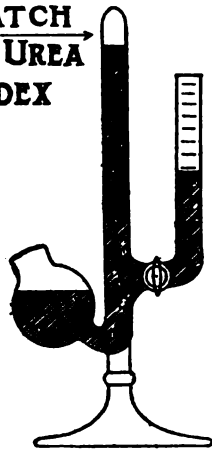

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Regarding the Vacuum Furnace which was installed in our house at 2419 Decatur street, we are here to say if we could not get another like it, money could not buy this one. It heats our seven rooms and bath comfortable. We are well pleased both in heat and economy in fuel. It heats the house above and below in a perfectly satisfactory manner.

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It gives us pleasure to tell our friends about the furnace. Wishing you success,

Yours truly, (Signed) C. M. HUMMEL AND FAMILY,
2419 Decatur St.

Note—This lady and her family appear to have good heat insurance besides the generous spirit of wishing to pass a good thing along. This was not a new home, but it is now a mighty sight more comfortable and all the cutting necessary to install **was one hole in one floor.**

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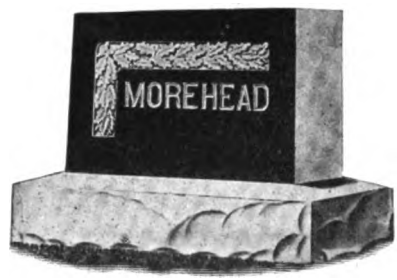

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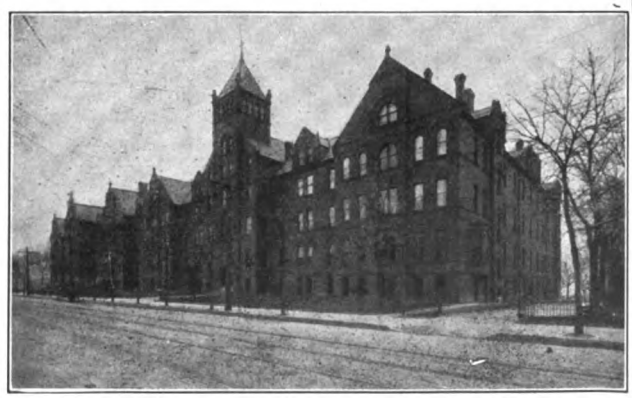

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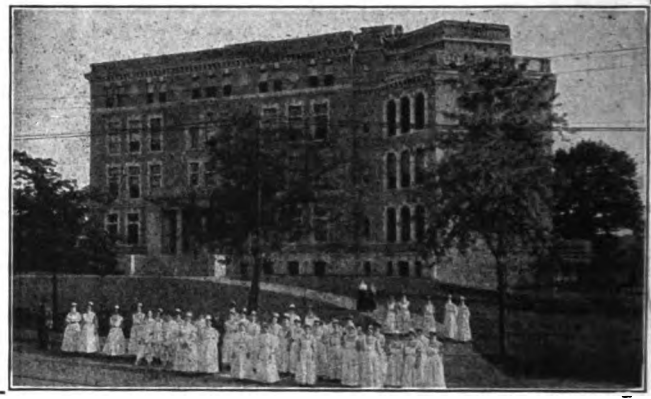

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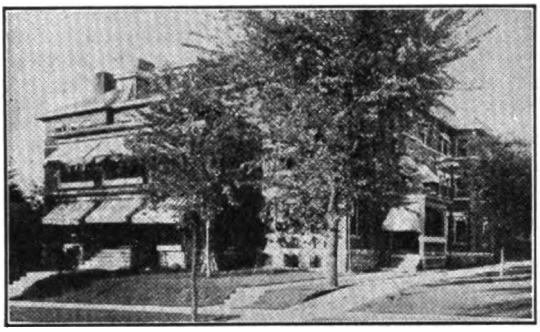

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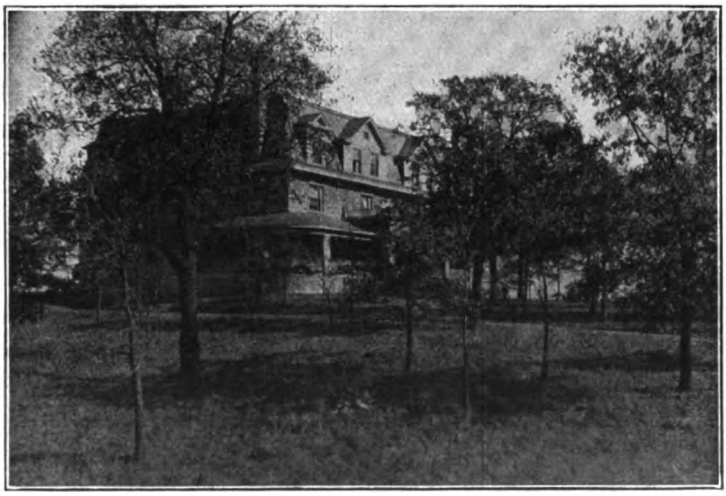

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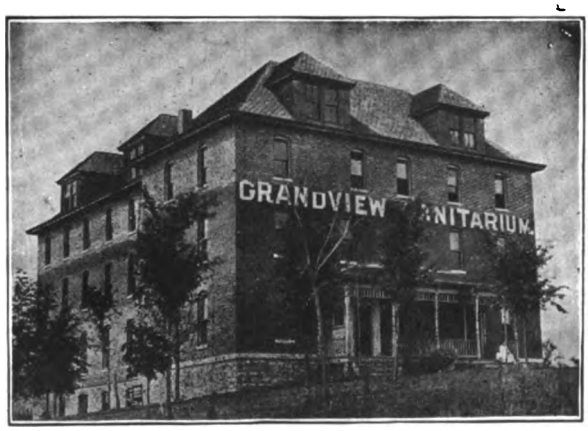

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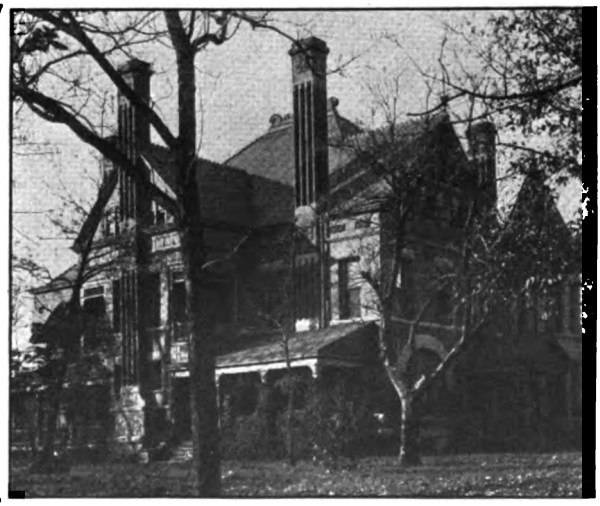

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EDITORIAL

Just to Remind You

Elsewhere in this issue of the Review we publish a brief statement from our State Association secretary to which we desire to call attention.

The success of the coming meeting at Hastings in May does not depend on the secretary or on the various section heads, but on the individual members, and those who wish to present anything before this meeting should promptly send notice of it to the proper section.

The secretary's statements in regard to the payment of dues needs no amplification. Get busy.

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Medical Testimony

We quote from the Ohio State Medical Journal (January, 1915, issue):

"It seems that the question of regulating medical testimony in the courts is finally to be given attention in Ohio. The Committee on Public Policy and Legislation is now in conference with a representative of the Ohio State Bar Association and it is hoped to develop eventually a plan of regulation whereby the disgraceful abuses existing under our present system will be modified and eliminated."

This is entirely desirable. Probably no other activity of the physician puts him in more unfavorable light before the general public.

It appears that our state legislature will have a chance to do something toward this desired change in testimony.

Senate File No. 14, by Quinby of Douglas County, among other improvements provides that a witness shall not be compelled to answer yes or no when such answer does not fully explain his reply.

This is certainly a good commencement towards doing away with the chicanery used only too often to prevent the truth from being told by witnesses in court, or to prevent the opposing attorney from exposing deliberate falsehoods uttered by witnesses. There is more time wasted and more injustice perpetrated by the use of these paltry artifices than can be imagined by those who are not familiar with our court practices. They only get a glimpse of these daily occurrences, when they read verbatim testimony in *causes celebre;* and who does not become disgusted before he has done reading these pettifogging exhibitions?

Any citizen, physicians especially, ought to assist in the passage of such meritorious measures. Speak to your legislators about this. It seems a small matter, but oh, how important it often becomes! A. S. v. M.

A National Board of Health

Under the caption: "Is this the First Glimpse of the Dawn

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of a New Era?" the Ohio State Medical Journal (January 15, 1915), page 3, says:

The Toledo Commerce Club by resolution has declared itself for a national department of public health, whose head shall be a member of the president's cabinet. This action of Toledo's well known civic organization is fraught with considerable significance to the medical profession.

For years we have battled alone against disease, facing calumny and insinuation, with no resources except the compelling desire to save life and prevent suffering.

Allied with the forces of sickness and death were the almighty dollars of the patent medicine interests, the advertising quacks, healers of all varieties and public indifference.

We have maintained that many deaths from disease are unnecessary, that much sickness is preventable, and the opposition has shouted, "Graft." We have gone before legislators with public health bills and the solons have asked, "What is there in it for you?"

We have gone before congress with a bill providing for a national department of public health, and the proprietary octopus, with its wide-spreading tentacles, sought to crush us under the ponderous accusation of being a "medical trust."

But now come to our aid allies more powerful than the patent medicine interests, stronger than the quacks, shrewder than the healers, and more potent than public indifference! allies with resources of wealth, intelligence and influence.

They are typified in the Toledo Commerce Club; they are the united business and commercial interests of our glorious country, and they come to our aid with the glowing realization that human life and good health have distinct economic and community values.

The action of the Toledo club will radiate to other similar organizations and the movement will spread; the responsibility will be partially lifted from our shoulders.

We commend the Toledo Commerce Club with feelings of relief and exultation.

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Every physician who reads these lines must feel how important this move of the Toledo Commerce Club will become, if its inspiration is transmitted to many more such organizations. Our State Medical Association's Committee on Public Policy ought to take up this matter at once and address itself to the Commercial Clubs of the State, especially those who are alive and progressive. If the establishment of a National Board of Health, whose head is a member of the president's cabinet, meant no more than an elevation of the present Public Health Service to this exalted rank, which place it has earned by its splendid service to the country long ago, it would only be a matter of justice long delayed; but, of necessity would stimulate its activities to still higher efforts, as ideals are never fully attained by the best of us.

But it would mean a great deal more: We will only mention one advance. The settlement of the disgraceful disparity in requirements for the practice of medicine in the several states of the Union.

It is time, high time, that the citizens of this republic, who are at all competent, should be permitted to practice their profession anywhere in this broad land of ours, and not be barred, as is now the case, by the limits of the several, the forty-eight states of the Union.

We are told that a diploma and state's permit to practice medicine in Germany is equally effective over its borders, in Austria and Switzerland.

If the requirements for practice were only identical here, the matter would not be so oppressive; but every state has its own hodge podge of requirements, from the most exacting to almost criminal abandonment and the perfection of this witch's broth has by no means been attained. The National Board will put an end to this nuisance and it cannot happen too soon.

A. S. v. M.

Time Limit for the Commencement of an Action for Damages in Malpractice

To the legislative medley presented in this issue of the Re-

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view we must add a small but very important bill, introduced by Mr. Lundgren as House Roll No. 434. It has only one section, which reads:

"No civil action for the recovery of damages on account of bodily injury or death suffered by any person in consequence of any malpractice, error or mistake of any physician or surgeon in the practice of his profession, shall be commenced by any person, or the personal representative of any person, against any such physician or surgeon, unless said action is commenced within one year after such cause of action founded upon said malpractice, error or mistake shall have accrued."

This is about the only measure, introduced at this session of our legislature, which affects the medical profession exclusively, and however just it may be, this very exclusiveness will be its undoing, unless the members of the profession see to it themselves that the justness of the measure is brought home to the legislators.

The Committee on Medico-Legal Defense of the Nebraska State Medical Association at this time has a case on hand against two very competent members of the profession, which originated in 1907, the time of an operation on the plaintiff in the case. He was then 17 years old. His father did not bring an action against the physicians, neither did he until three years after he reached his majority; seven years after the operation! At a time when many of the persons, who were cognizant of the patient at the time of the operation, the data of interest accompanying this work and the immediate results thereof, have been lost from sight, or have only vague recollection of the occurrences; when, as is usual, the real or imagined mole hills of the plaintiff have grown into mountains; to remove which the defendants will have a herculean labor to perform and for what? To show that their work was well done; or suffer the things that a verdict against them will inevitably bring with it—the loss of hard earned money, a smirch on their professional capacity—besides a lot of worry and sleepless nights.

These additional burdens are placed on the defendants unnecessarily and can and ought to be avoided by limiting the time

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action may justly be brought for damages. This bill ought to become the law of the state and every one concerned, lawmakers and physicians, ought to do their best to accomplish the task.

A. S. v. M.

The Requisites of the Modern Doctor

To achieve the greatest success in his practice, the modern doctor must be a man possessed of logical mind, medical skill and moral courage. He must not only be able to recognize the early signs and symptoms of diseased conditions, and to draw correct conclusions therefrom, but must also have the courage to tell his patients of his findings truthfully and fearlessly. * * * On the other hand the doctor of today owes a duty to the state. * * * By reporting promptly all cases of communicable disease that come under his notice, the doctor lends a valuable service not only to the community but also to his individual family. A man who allows cases of diphtheria to go without treatment until they are moribund, who refuses or fails to recognize tuberculosis until the lungs are filled with rales and the sputum with tubercle bacilli, or who neglects cases of cancer until they are inoperable, or at least beyond recovery from operation, has no place in the modern practice of medicine. The people are demanding better things and they are entitled to more consideration; on the other hand men who are prepared to practice modern medicine need have no fear that there is no demand for such service.—Guy L. Kiefer, Journal Michigan State Medical Society, October, 1914.

If you have the slightest appreciation of The Western Medical Review, shown it by patronizing the advertisers, for the advertisers must receive your patronage in order to justify them in continuing their advertising, and The Western Medical Review must have the advertising in order to exist. You, appreciative reader, may not know that for the year 1914 the publication of The Western Medical Review cost nearly one thousand dollars more than it has cost for any preceding year, and yet such is the case, and the increased cost is coming from the advertising income and not from what you have been paying as a subscription.

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ORIGINAL ARTICLES

Diagnosis of Glaucoma

*By H. B. LEMERE, M. D., Omaha

During the last decade the greatest advance has been made in the diagnosis and treatment of glaucoma. This indeed represents the greatest accomplishment in the science of ophthalmology for this period. As in arterio-sclerosis, glaucoma can be termed a condition rather than a disease. It is a condition of increased tension of the globe. There are undoubtedly underlying causes for this increase of tension, but our knowledge of them is limited and they are undoubtedly of a complex nature. Their study, while of interest academically, is at present not of very great practical value, as, after an eye becomes hard no treatment of the general or local condition, short of operative procedure, will bring it permanently to normal tension. The diagnosis of the condition is extremely important, as the tension of the globe means continuous pressure on the head of the optic nerve, with a certain prognosis of atrophy and partial of complete blindness.

The classical symptoms are dilation of the pupil, shallow anterior chamber, excavated head of the optic nerve, contraction of the field of vision, central scotoma, hardness of the globe. The dilation of the pupil and the shallow anterior chamber are both the result of the increased tension. In acute inflammatory glaucoma the severe pain and injection must be due in great measure to the increased tension, as they do not appear when increased intra-ocular pressure is rendered impossible.

When we say glaucoma, then we simply say increased tension of the globe. As with arterial tension so with the tension of the globe, it was customary to attempt to gauge the degree of tension by palpation. Two fingers making alternate pressure on the globe gave the physician his impression of the hardness of the globe. The tension was recorded T plus 1, T plus 2, T plus 3, according to the tension being barely discernible, moderate, or producing stony hardness respectively. This was obviously crude and unless the impression received of slightly increased hardness was fortified by some other of the cardinal symptoms, the custom was to wait until such additional symptoms made their appearance before any definite effort was made to reduce the increased tension. It is easy to see the certain damage per-

*Read before the Nebraska State Medical Association, at Lincoln, May 13-14, 1914.

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manent in nature, which must result from such delay, and any means which would give absolute measurement of the tension of the globe would be of wonderful benefit in determining early the necessary treatment, almost one might say in determining prophylaxis, as by reducing the tension before atrophic changes in the optic nerve have occurred such changes are prevented.

The ophthalmoscopic picture of cupped disc is easy to recognize, the vessels sharply turning over the edge of the cup, disappearing and reappearing, and the whitening of the nerve head, yet I had occasion to see a case in which there was a funnel shaped depression in the center, but no depression of the circumference of the nerve, there being present only what is generally known as a physiological cup. The vision was 20-15 and there were no signs of any increased tension. These observations were made four years ago. Two months ago this man appeared with the history that he had no pain or any other symptom referable to his eyes, but the vision in the left eye had been getting worse for the past year. Examination shows vision in right eye 20-20, in the left eye only shadows. The right field was normal for white, sligtly contracted, especially on nasal side, for red. The pupils were slightly sluggish to light reaction. They were about 4 m.m. in diameter, and the anterior chamber was normal in depth. The left eye showed a marked glaucomatous excavation of the optic nerve. The tonometer read 40 mm Hg in the right and 70 mm Hg in the left, normal tension being 18 mm to 24 mm. This observation that an excavation identical in form with a physiological excavation may exist with increased tension is noted by Elliot. It is almost incredible how an apparently intelligent patient with glaucoma simplex will often allow his vision to deteriorate before seeking medical aid. The burden therefore of discovering this condition in its incipiency is on the ophthalmologist, often when the patient has consulted him merely for a change of glasses and gives no history of any sign of increased tension.

The finality and exactness with which the tonometer settles the diagnosis, enables the physician to speak with such certainty that often the patient is convinced, and it is possible to take procedures necessary to preserve the sight.

The danger after dislocation of the lens is in increased tension. The following case will illustrate the value of the tonometer in determining the active danger from among several evidences of former injury.

Man, aged 29, consulted me June 29, 1913. He stated that two

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months ago he had been struck a glancing blow on the left eye by an iron bolt ten inches by one-half inch, at the same time breaking his cheek bone and loosening his teeth. Examination showed vision 20-70 unimproved, a rupture of the choroid and a rupture of the deeper layers of the cornea. The lens had some opacities on the anterior capsule and was dislocated about 3 mm. downward and to the temporal side. The man stated that his eye had not pained until the night previously. With these several injuries there was a possibility of the pain being due to dazzling from the condition of the lens or choroid, or the iris might be irritated by the changed position and condition of the lens. The tonometer, however, showed a tension of 44 mm Hg in the injured eye and 24 mm Hg in the uninjured eye. Following this indication, operative procedures were undertaken for the relief of the tension which gave the patient complete and permanent relief.

The use of the tonometer is very simple. A few drops of local anesthetic are instilled into the eye. Holocain receives the preference in that it causes no dilatation of the pupil and does not affect the tension of the eye. It is also reputed to have some antiseptic value.

The eye, being anesthetized, the patient lies flat on his back without any pillow. As he looks to the ceiling the instrument is applied, the facet resting on the center of the cornea. The harder the eye the less the center rod can sink and the less is recorded on the dial. The proper weight is on when the indicator points to 4 or its vicinity. Readings less than 2 or more than 6 are unreliable and weights should be changed till the pointer is near 4. Three readings are taken and if there is any slight variation an average is made. The weights are 5.5, 7.5, 10 and 15 c. m., respectively.

The diagram sent with the instrument translates the readings on the scale of the instrument into the corresponding pressures of a column of mercury.

I have tried to make these few remarks of an intensely practical nature, and if I have neglected dwelling on the signs and symptoms of glaucoma which formerly were of such great value in the diagnosis of this condition, it is because the exact measurement of the pressure by the tonometer is now considered the all determining factor in the diagnosis of glaucoma.

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Recent Operative Procedures in Glaucoma

*By J. M. PATTON, A. M., M. D., Omaha

The classical symptoms of glaucoma and their serious consequences were recognized by the very early ophthalmic investigators and Guerin of Lyon, writing in 1796, advised in case medicinal measures failed, that a puncture be made through the sclera to allow the escape of, in his opinion, an excess of vitreous.

Since the days of Guerin numerous operations have been devised, but the posterior sclerotomy, as we call it, is still a very useful palliative operation and in an acute glaucoma where the tension does not respond promptly to myotics, the attending physician need not hesitate to reduce the pressure in this way. Our technique is as follows: After washing out the conjunctival sac, a few drops of 3 per cent cocain and adrenalin are instilled. After a few minutes 3 to 5 drops of a 10 per cent solution of cocain is injected under the conjunctiva just back of the insertion of the inferior rectus. A triangular conjunctival flap is then laid back and a suture passed from the edge of the conjunctival wound to the tip of the flap ready for immediate use. The blade of a Graefe cataract knife with the cutting edge toward the cornea is then inserted through the sclera 7-16 inch from the limbus and a 1-8-inch cut is made toward the cornea. The blade is then turned at right angles and an incision made of the same length. The vitreous presents promptly and the conjunctival wound should be closed at once by tying the suture already in place.

Paracentesis of the anterior chamber is a simpler operation than the above and gives relief for several hours. After cocainizing, the blade of a very sharp cataract knife is inserted in the conjunctiva 1-8 inch from the limbus, passed subconjunctivally to the limbus and through into the anterior chamber, the incision is widened to 1-8 of an inch and the aqueous allowed to escape. Great care must be observed not to injure the lens. This may be repeated several times if necessary.

Following the introduction of iridectomy for the relief of glaucoma by Von Graefe about the middle of the last century, little progress was made in handling this condition, it being generally conceded that if the iridectomy did not give relief, the case was hopeless. However along toward the close of the last century it was observed that those cases in which the iridectomy was followed by a filtering cicatrix were free from

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tension; when there was solid fibrous union, the tension recurred. This having been gradually recognized, much experimental work was done to determine the best method of producing a filtering scar. The question to be solved was, why did some iridectomy wounds heal with a cicatrix which permitted the escape of aqueous beneath the conjunctiva, while others did not. Some observers, notably De Wecker and Herbert, thought this filtration was due to fibers of the iris having been caught in the healing wound, and in their operations encouraged a certain degree of iris prolapse to take place. But this was found to be uncertain and at the same time the prolapsed iris presented a certain element of danger. To avoid this Herbert attempted to introduce a fold of conjunctiva into the scleral wound. A little later, 1903-1904, he brought out an operation in which he made a wedge shaped flap of the anterior tip of the scleral wound. Various modifications of Herbert's operations were devised, and taken as a whole, were a decided step forward in the management of glaucoma.

In the meantime, Heine had been working out his operation of cyclo-dialysis, and published an account of it in 1905. By this method he attempted to establish permanent connection between the supra-choroidal space and the anterior chamber, by passing a dissecting spatula through the wound in the sclera and detaching the base of the ciliary body for a space of several m.m. The results of this procedure were rather uncertain, though of undoubted benefit in many cases.

But observers were still endeavoring to produce a filtering cicatrix and in 1906 LaGrange combined a sclerectomy with an iridectomy. He makes his incision with a narrow cataract knife just back of the limbus with a rather large conjunctival flap. The anterior lip of the scleral section is then cut away with scissors which should be very sharp. The iridectomy is then done in the usual way. LaGrange does this under cocain anesthesia and excellent reports have been published both by the originator of the operation and a number of careful operators in Europe and America. Our experience with this operation has not been altogether satisfactory. An attempt to produce a filtering condition without actually perforating the sclera was attempted by Bettremienx, who snipped away the outer layers of the sclera just outside the limbus for one-fourth to one-third the circumference of the cornea. He reports success, but the operation has not been generally adopted.

In the meantime, two men, working quite independently, the

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one in Scotland and the other in India, published almost simultaneously the report of an operation that marks the greatest advance in the treatment of glaucoma since the days of Von Graeffe. I refer to the scleral or sclero corneal trephining as devised by Fergus of Glasgow and Colonel Elliot of Madras. Dr. Fergus reported his findings a few weeks before Colonel Elliot, but the latter knew nothing of Dr. Fergus' work when he published his results and as there seems to be a decided advantage in the technique as practiced by Elliot, the operation generally goes by his name. Briefly the technique is as follows: After thoroughly anesthetizing the conjunctiva, sclera and iris with cocain and rendering them as nearly bloodless as possible with adrenalin, a large conjunctival flap is turned down, the outer limits of the flap being on a level with the upper limbus and at least 3-16 inch from the cornea laterally. Then being exceedingly careful not to perforate the flap, the dissection is extended into the cornea, elevating the superficial layers for a distance of 1½ to 2 m.m. The trephine is then placed as near the base of the flap as possible without button-holing it and a disc removed which if the splitting of the cornea has been done properly, should be part sclera and part cornea. Usually the iris protrudes through the trephine hole and the prolapsed portion should be seized with iris forceps and cut off. The edges of the iris wound should retract from the base of the trephine opening, leaving a free communication with the anterior chamber. Colonel Elliot does not think the iridectomy has any influence beyond relieving the mechanical obstruction of the trephine opening. The conjunctival flap is then replaced either with or without a retaining suture. Personally I think the suture of advantage. Various forms of trephines have been devised, but all acting on the same principal. Some have a small hook or screw for holding the button of sclera. These have not been of any advantage in our experience. Some prefer the spring or electric driven trephine. As to size, the trephine having a diameter of 1½ to 2 m.m. apparently gives the best results. Various punch forceps have been devised for removing a small piece of sclera, but so far they have not come into general use.

In 1912 Mayo and Zorab reported a group of cases in which a loop of silk thread had been inserted into the anterior chamber either by means of a needle or through a subconjunctival incision, the silk remaining and acting as a permanent drain. Within the last year one of the originators at least has reported that owing to the uncertainty of the silk remaining in place, he has abandoned the operation in favor of trephining.

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In looking over the literature, one is impressed by the general way in which this operation has been received by representative oculists of the world, a few, while admitting the value of the operation, still prefering the iridectomy and a still smaller number holding to the sclerectomy of LaGrange or one of the punch operations.

However, the operation is not an absolute cure-, although Colonel Elliot employs it in cases of acute glaucoma. Many conservative men still depend on the iridectomy in these cases. In the subacute or chronic inflammatory types simply relieving the tension does not always clear up the pain and inflammation and the patient may insist on having the eye enucleated for the sake of immediate relief. Occasionally the anterior chamber is slow in reforming or there may be a low grade iritis follow, which is apparently due more to the original inflammation than to the operation, and finally a few cases have been reported where there has been late infection through the conjunctival flap, covering the trephine opening. We have had one such experience. These drawbacks are, with the exception of the last, also present in the other types of operation for this disease and cannot be justly attributed to trephining.

Of the errors in technique, too small a conjunctival flap, failure to get the trephine opening sufficiently into the cornea and neglect or inability to remove the portion of iris beneath the trephine opening are the most frequent causes of imperfect results. However the numerous advantages of this operation are apparent, and judging by the popularity of the procedure, greatly surpass the disadvantages mentioned above.

The operation, while not particularly easy, is safer in the hands of the average operator than an iridectomy. There is very little danger of wounding the lens or of an escape of vitreous. If a general anaesthetic has been given, little if any harm can result from post anaesthetic vomiting. If an iridectomy does not give the desired result, it is very difficult to repeat the operation, while trephining may be done several times on the same eye if necessary. One thing that appeals to the patient is the cosmetic result. It is only necessary to remove that portion of the iris that presents through the trephine opening and need not involve the sphincter pupili at all. This both preserves the symmetry of the eyes and retains an active pupil, which is of value should an iritis develop. But it is the influence of the operation on tension, vision and visual fields that interests us primarily. Again Colonel Elliot does not claim that the

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tension will be permanently reduced in every case, but he does insist, and our own expérience and that of others who are regularly employing this operation, coincides with his that when the operation is properly done the results are better than those following the other forms of operation and should the tension recur it is comparatively easy to retrephine. Improvement in visual fields and visual acuity has been unexpectedly good in a number of our cases, and the average fully up to that of the classical iridectomy. Considering the decided improvement in tension, fields and vision, the lessened danger, the increased comfort to the patient and even the cosmetic results, I would not hesitate to recommend corneoscleral trephining as the operation of choice in all cases of chronic glaucoma and glaucoma simplex and there is undoubtedly a field for its use in the acute inflammatory types as well.

DISCUSSION

Dr. H. B. Lemere, Omaha:

Dr. Lemere, with the assistance of Dr. Hompes, demonstrated the use of the Schiotz tonometer. The tonometer is an instrument for measuring accurately the tension of the globe. The boy on whom the demonstration was made, having a normal eye, the tension registered was 25 mm. of mercury. The normal eye may register between 18 and 28 mm. of mercury.

The scientific accuracy of this instrument has made it possible to detect glaucoma simplex at its very early stages, which it is impossible to do without the instrument.

Before answering the discussion on my own paper I wish first to make a few remarks on Dr. Patton's very scholarly paper. In order to appreciate the great advance made in the past few years in the diagnosis and treatment of glaucoma it is interesting to look back at three decades of scientific effort and observation which have finally given us the Schiotz tonometer by which we can diagnose glaucoma in its early stage and the refinements of Elliot's trephine operation by means of which we can hold this increased tension in check.

At the International Congress in London in 1913, the main feature of the program of the ophthalmological section, was the symposium on glaucoma with Mr. Priestly Smith, Colonel Elliot and Prof. LeGrange as essayists. The record attendance at the meeting and the enthusiastic applause of these men showed the realization by the foremost ophthalmologists of the world of the gain that had been made in the treatment and diagnosis of glaucoma.

It requires a great deal of courage on the part of both surgeon and patient to accept an operation on an eye which is without pain or inflammation and whose vision is being lost so gradually as to be almost inperceptible in its progress. The tonometer shows the condition so absolutely that the diagnosis is understood by the patient and his friends and the confidence of this evidence makes successful treatment possible in many of these cases.

In regard to Dr. Summer's criticism, as no injury is done the epithelium of the cornea in this test, it does not call for extreme refinement of technique.

Dr. Harold Gifford, Omaha:

I think Dr. Lemere's demonstration of the effect of the tonometer and his explanation of the value of the instrument are excellent and I think no one would disagree with him. In the present day we cannot expect to treat

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glaucoma without the use of the instrument which he has shown. The trephining of the sclero-corneal junction as described by Dr. Patton is probably the most important advance in the treatment of glaucoma. But I do not think this subject ought to be allowed to pass in a general meeting of a medical association without emphasizing a few of the principles which are of the greatest importance to the general practitioner in connection with glaucoma. There are just two mistakes commonly made in diagnosing this condition, one is to mistake an acute glaucoma for an acute iritis. The symptoms are very much alike, discoloration of the iris, pain, redness, etc. I should say that three-fourths of the cases of acute glaucoma are taken for iritis and treated in exactly the wrong way, greatly damaging the chances of the patient for permanent relief. The other mistake is the mistake of chronic glaucoma for cataract. A person who is not experienced tells the patient to go on until his cataract gets mature and then have it operated on and by the time the sight is anything like as bad as it is in mature cataract, the glaucoma is so far along that the patient is hopelessly blind. Keep in mind the fact that these two forms of glaucoma occur and each is liable to lead to a serious mistake.

Dr. Patton, closing:

I think that the subject of glaucoma is occupying more of the attention of the ophthalmologists than any other thing. At our national meetings the question is always before us and tremendous strides have been made in the diagnosis and treatment of this condition. I feel that the question Dr. Lemere brings out about the tonometer is one of great importance to you gentlemen in general practice. It is safe to use, the expense is not considerable and the satisfaction that is derived from its use is very great. You know the anxiety that you have where you have a patient that is losing his sight and has inflammatory symptoms, which may mean either iritis or glaucoma. If you have an instrument that will determine satisfactorily whether that patient has glaucoma or not, it will relieve you of considerable anxiety and perhaps be the means of preserving your patient's sight. And in the use of the trephine, Colonel Elliot, who has had more experience than any one else, and has done over a thousand operations by this time, has no hesitancy where it is hard to keep the patient under observation, in trephining the second eye at the same time he does the first, thereby saving the patient from further danger. I am thoroughly convinced that for those of us who have not had the wide experience of Colonel Elliot and Professor La Grange, the operation of trephining in these cases at least, is the operation that will give us the best results in the large average of cases.

Tarsectomy Versus Trachoma

*By JAMES E. REEDER, M. D., Sioux City, Iowa

It is a well known adage that the presence of an organ or tissue cannot be considered as among the causes of its disease. While this is manifestly true, the surgeon is very busy removing certain diseased organs and tissues which are not only not essential, but which in certain altered states are detrimental to the individual's well being.

It is now well known that trachoma owes much of its treatment resisting reputation to a chronic tarsitis. We know that were the tarsal plates absent the later course of the disease and

*Read before the Sioux Valley Medical Association, at Sioux City, Iowa, January 20-21, 1915.

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its many complications would be greatly modified and the disease in itself very much shortened.

The importance of the tarsal plates, both anatomical and physiologic, is evident. With the septum orbitale with which they are continuous, they form an entire layer of the lid.

They give form and framework and proper density to this structure. They protect the eye ball. They contain essential granular structure and furnish attachment for the lid muscles. While on the contrary, when diseased all of these functions may be altered, so hence in their altered state may become an actual menace instead of a protection to the eye as they do in a normal condition.

Trachoma is unusual in this way, that it appears to be the only disease in which there is a primary involvment of the tarsi coincident to or with the conjunctival infection. The very worst cases of gonorrheal conjunctivitis do not involve the tarsus at all. In simple forms of chronic conjunctivitis, such as the exposure of the conjunctiva due to ectropion, and after acute blenorrhea, you always see a papillary hypertrophy of the conjunctiva, but from none of these do you see an involvment of the tarsus. On the other hand, it is a question if any case of true trachoma leaves the tarsus uninvolved. In fact, if there were no involvment you would question your diagnosis.

Raehlmann says: "A series of clinical and histologic studies and my experience in the last ten years justify the conclusion that in inveterate trachoma there is an early development of trachomatous tarsitis which keeps pace with the various phases of the disease and has a decided influence on its course." It appears then that he believes the cicatricial changes seen in the tarsus are due to the primary involvment of the tarsus itself and not to the conjunctival infection.

Trachoma is noted for its chronicity, its tendency to exacerbations and by its reinfections or secondary infections. For these reasons we do not know why a "trachoma" will be doing well and all at once become very much worse and all you have been doing for several weeks or months has gone for naught.

Beard says: "The fornices, especially the upper, are the store houses or reserve stations of the trachomatous infection." "They often resist all medical and mechanical treatment. It is from these that start the relapses that have made the handling of these cases so discouraging."

Beard also states that this is the site of most reinfections.

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It is a question what is the cause of these exacerbations and not until the cause of trachoma is known will we be able to determine such. I recall one case I had charge of where a man who had a trachoma developed an attack of gonorrheal ophthalmia. It was one of the very severe types and was a long time in getting well and it was not until the acute symptoms subsided did we discover he had trachoma, he being an illiterate. But finally we obtained a history of sore eyes some years previous, but had no trouble for two or three years since until he developed this attack of gonorrhoeal ophthalmia. It was very evident then the old trachoma was lighted up by this attack. Hence the long time for recovery.

It has been shown where foreign bodies have been the cause of starting a relapse, also the Morax-Axenfeldt bacillus has been noted to be the cause of a trachoma flaring up, as it were.

Woodruff says: "The favorable results which follow the removal of the tarsus in old relapsing trachoma indicate, beyond question, that in some way this tissue itself, probably mechanically, is the cause of the exacerbations in the majority of cases with corneal involvment."

It is said that Heisrath in 1882 discovered the value of tarsal removal by accident. Desiring a piece of the tissue for study or histologic examination he removed a portion 4 m.m. in width and 1.5 c.m. in length. To his surprise the patient was very much improved. He then proceeded to perform the same operation a number of times and later to publish his results in 230 cases. Following him there have been many valuable contributions on the subject, notably Kuhnt, who is an authority on the subject.

Technic: The usual site for the conjunctival incision is along the upper border of the tarsus. The position of the incision should vary according to the type of cicatrization.

In the normal state the conjunctiva can be scarcely separated from the tarsus. In many cases of old trachoma the conjunctiva is drawn over the tarsus down to the sulcus sub-tarsalis scar which is characteristic in the majority of cases. Beneath this area the local anesthetic can be injected which assists in the dissection much as the mucous membrane is lifted from the nose in the sub-mucous resection.

It is but a moment's work to dissect around the border of the tarsus as closely as possible so that the musculature will not be injured.

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Grab the lower border with a fixation forceps and proceed to remove the tarsus as close to the lid margin as possible. This is best done with a pair of scissors. The piece often seems very small as compared with the normal tarsus. This is due to its long continued involvment. The wound may now be closed with two or three silk sutures; some advocate no suturing at all.

The important points are: 1. To remove all of the cicatrized and deformed tarsus except that part close to the lid border.

2. Do not remove any tissue except the tarsus and the conjunctiva which can not be separated from it. Do not remove any muscle.

Place the sutures so that there will be as little as possible to come in contact with the cornea.

I have the following case to report, which is typical of results in properly selected cases. As the operation is only indicated in subacute and chronic cases, especially where there is marked pannus with frequent exacerbations.

History: Mr. R. C., aged 30; referred to me August 8, 1914. Patient states that his eyes have been sore for the past two years; has run the gamut so fas as treatment is concerned. Both eyes operated on shortly after contracting the disease (evidently an expression). They were some better after that, but gradually bcame worse and for the past year has been unable to get along alone on the streets and has been a ward of charity for some time.

Vision: R. E., fingers at six inches; L. E., fingers at six inches. There was marked pannus over both corneae and the ptosis was very severe.

Treatment: First two weeks consisted of boric wash, atropine ointment 4 per cent t.i.d. and copper sulphate once daily to the lids. At the end of two weeks there was no improvement and I advised the removal of the tarsi.

The right tarsus was removed August 24, 1914. In two weeks the vision of the right eye had improved to 10-200. The patient was then willing to have the left eye operated on, which was done October 8, 1914. A boric wash was prescribed for home use and the pannus has gradually cleared since that date. The present vision B. E. is 20-70 or 3-10. The patient is now able to do odd jobs and help support his family and I trust will soon cease to be a ward of charity.

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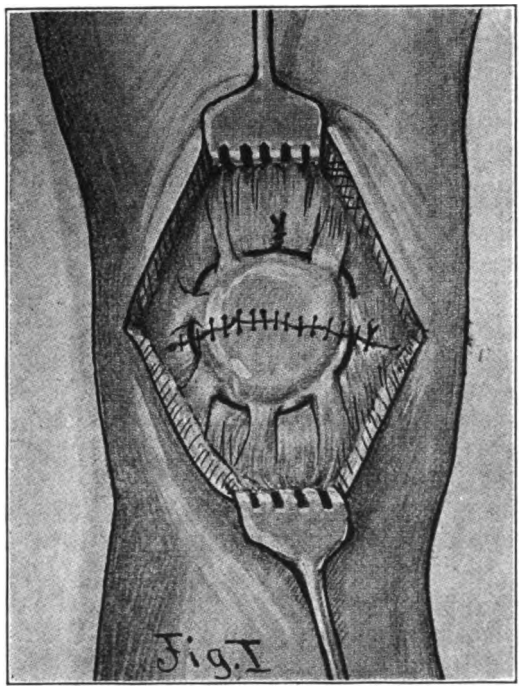
An Efficient Operative Treatment for Fracture of the Patella

By H. W. WIGHTMAN, M. D., Omaha

Acute fractures of the patella are best operated upon the fourth or fifth day following the injury. By this time the usual traumatic inflammation has subsided, thus reducing the chances for operative infection.

Before operating upon old fractures of the patella it is advisable to make the knee joint more resistent to infection by injecting directly into the joint 2½ drams of a twenty-four hour-old 2 per cent formalin in glycerine solution eight days prior to the operation.

In the operative treatment the general rules applicable to the surgical treatment of fractures must be followed, such as absolute asepsis, hemostasis and the removal of all interposing soft tissues between the fragments. Blood clots and foreign material, if present in the joint, is best removed by irrigation with one-half per cent salt solution.



Method 1. Figure 1 is recommended for all acute or sub-

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acute fractures. A longitudinal incision about four inches in length is made directly over the fractured patella. The superficial fascia down to the tendo-muscular layer is undermined and retracted. The patella is circumscribed by a No. 18 silver wire purse string introduced well along the center boundary of the patella as shown in Figure 1. The wire is twisted, drawing the segments in close apposition. A second suture approximates the tendo-periosteal tissues, using a twenty-day No. 1 chromic cat-gut. Skin wound is sutured with the lock stitch, using No. 0 chromic cat-gut, dry greasing applied and the limb kept in a straight position by means of a posterior splint for six weeks.

A ten-minute massage about the anterior and lateral aspects of the knee joint is begun after the fourteenth day and continued daily for six weeks. Posterior splint reapplied after each massage. Slight degree of passive flexion and extension of the leg daily after the sixth week. Posterior cast permanently removed after the sixth week, slight active movements after the eighth week and no considerable extension force to be used before the end of the fourth month. On an average the patient should not walk without a cane or a crutch before the tenth month.

(To be continued in later issue.)

The Killing of the Tetanus Germ at the Point of Infection With Ultraviolet Rays

E. Jacobstahl and F. Tamm, of Hamburg, reported at the Hamburg Medical society, November 17, 1914, as follows:

Tetainus spores as well as germs of the anerobic type of the malignant edema group are quite sensitive to the ultraviolet rays. We have, therefore, exposed infected wounds as well as those experimentally infected to the rays of Kromayer's quartz lamp. In a number of cases we were able to kill completely these bacteria in the wounds. The rays from the artificial sun are very well borne for fifteen to forty-five minutes, with a distance of 25 c.m. between the lamp and the thorough protection of the uninvolved area. The application of the quartz lamp rays to deep pockets and wounds is undertaken with the aid of special, movable quartz sticks. On account of the marked toxic content of the point of infection, we advise surgical cleansing of the wound. The application of the rays supplement the other procedures in well developed cases to a remarkable degree.

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CLINICAL REPORTS

Echinococcus Disease, Report of a Case

Echinococcus disease is of such rarity in this country—only 150 cases having been reported up to a few years ago—that the report of this case is deemed advisable.

The patient was a Greek. The most frequent occurrence in this country has been among the Greeks. He could not speak English, so the history is unsatisfactory, but it was learned that as a youth in Greece he had had some trouble in the region of the liver. About one month before coming under our care the patient had been in a hospital a week and treated for pneumonia. He improved sufficiently to leave the hospital, but continued to cough a great deal and did not regain strength. At first observation the patient had the appearance of great illness, coughed incessantly and had a low fever. The physical examination showed absolute dullness over the lower posterior area of the right chest. The respiratory murmur was inaudible over this area. A tumor, soft, tense and transmitting a peculiar thrill on percussion, was present in the right epigastrium apparently closely associated with the liver. The palpable portion of the tumor was as large as an orange. The nationality and the cystic tumor with a thrill that corresponded to that described for the echinococcus cyst suggested that disease and the question of the chest symptoms being the result of extension from below arose. Frequent examinations of the sputum were made. In these examinations we did not find hooks or other evidence of echinococcus. A further report of the sputum findings will be incorporated in the pathological report.

We inserted into the chest a fair sized aspirating needle two times with the result that a spurt of reddish yellow fluid escaped then sudden complete stoppage of the flow occurred. The subsequent findings showed this to be due to the obstruction of the needle by the impingement of a cyst upon it. Examination of this fluid revealed characteristics similar to the sputum and no hooks or other evidence of echinococcus were found. The patient became rapidly emaciated and ran an irregular temperature of moderate degree. Despite the negative results from the aspirating needle, it was deemed advisable to open the chest, which was done by resection of three ribs. There escaped from the wound about two quarts of yellow pus tinged with red and about 200 cysts of all sizes from pin-head to an orange. All of these cysts were brown, collapsed and dead. In the subsequent

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drainage other cysts appeared from time to time. The temperature fell, the general condition improved and some flesh was regained. About one month later a second operation was performed to remove the large cyst connected with the liver. The mother cyst here was attached to the under surface of the right lobe of the liver. It extended downward into the right illiac fossa and upward apparently as far as the diaphragm. From this cyst probably as many as two or three hundred daughter and granddaughter cysts were evacuated. These were all white, distended with clear fluid and alive. In this fluid hooks and scolices were found, but not with ease until the special method described later was employed. The inner lining of the mother cyst was stripped off as well as possible and drainage established. Convalescence was slow, but eventually after several months he returned to work. The gain in weight was such as to return him to the normal. In fact, he became quite fleshy, probably weighing in the neighborhood of 175 pounds. The abdominal wound closed soon, but there was drainage from the chest for several months. This finally closed and remained so for two or three months during which period his health was very good. He then developed a recurrence of the discharge from the chest wound and a cough. He lost flesh and expectorated two or three collapsed brown cysts. Since then he returned to Greece and has been lost sight of.

Pathologic Report: The blood showed a leucocytosis. Repeated special stains for eosinophilia failed to disclose any increase. A careful search was made of the sputum on several occasions. Peculiar highly refractive irregularly shaped reddish yellow crystals were numerous. These we have seen in no other exudate or fluid and could find no reference to in available texts. We have wondered if it may not have some diagnostic importance in echinococcus of the lung in which nearly always the parasites are dead. It was thought that these bodies were likely the product of the dead cyst.

In the search for hooks and scolices in the fluid taken directly from the live cyst it was found not to be so easy as the text books would indicate. The following method yielded an abundance of scolices, but few detached hooks and is presented as a valuable method where the study of a fluid encompasses the possibility of echinococcus disease.

Centrifuge the fluid for several minutes and smear the sediment on a clean slide. Dry in the air and fix by quickly passing through the flame three times. Stain with haem-alum or haem-

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atoxylin and eosin in the same manner as for pathologic tissue The scolices are usually abundant in the specimen and stain well. RAMEY AND EMERSON (Lincoln).

Three Cases of Achlorhydria Hemorrhagica Gastrica

By GEORGE SHIDLER, M. D., York, Neb.

Recently three interesting cases of achlorhydria hemorrhagic gastrica came under our notice, and, as they are perhaps more common than we imagine, and frequently present such strange symptom-complexes, we shall briefly report them.

Case 1. Miss M. T., age 24; family history, negative; suffered for ten years with indigestion supposed to have started from eating spoiled food; gradually gained weight all these years; constipated usually; severe dysmenorrhea since puberty; cramps in right lower abdomen between periods, alternating with gastric distress; frontal and occipital headaches frequent, worse after meals; appetite capricious, generally good; thirsty most of the time; taste often bitter, no relation to meals; sensation of bloating and fullness in stomach; belches before and after meals; epigastric pain, not in relation to food ingestion; no "food ease"; pain dull and boring, again sharp and colicy, not increased by position or pressure, more marked in right hypogastrium at menstrual period; sometimes has general abdominal pain which is never present during a gastric crisis; tenderness all over stomach; nausea, most often just after breakfast, sometimes before; vomitus, small in quantity, brownish or yellowish, sour smelling and bitter, sour tasting, occasionally blood streaked, some mucous and bile; vomiting sometimes relieves pain; never has had hematemesis.

Physical and Special Diagnosis: Negative heart, lungs, spleen and kidneys.

Stomach: No tenderness, slight tympanitis, hypermotility; gastric contents, free HCL absent, 24.5 combined HCl, lactic acid present; no twelve-hour retention; X-ray bismuth meal negative, no incisura, no fill, no tenderness along greater or lesser curvature.

Intestines: Slight tenderness over right lower quadrant, tympanites and gurgling on pressure; stool examination gave positive blood test.

Patient refused operation. Several months later had acute right side attack with abscess which was drained. Complete recovery with disappearance of gastric and intestinal symptoms.

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Case II. A. G., male, age 42, married farmer. Complains of gastric and intestinal tympanites for fifteen years with sensation of weight and fullness after meals. Has never vomited nor had real stomach pain. Was treated once for nervous dyspepsia. About seven years ago, while scooping corn, felt a "slight catch" in right hypogastrium which went away, but has reappeared off and on with varying degrees of severity, sometimes reappearing as a real attack of abdominal colic relieved by passing gas; tympanites alternates with gastric disturbances; was a time that food seemed to relieve distress; no jaundice; no chills and fever; never has had noticeable tenderness in right lower hypocondrium; lost fifteen pounds in weight.

Examination: Skin sallow, pale mucous membranes. Negative in general up to gastro-intestinal tract; tongue white; mawkish breath; epigastric tenderness on pressure and along right edge of ribs; none in right hypocondrium on three examinations, neither at McBurney's or Morris' point, nor lumber plexes sensitiveness; gastric contents; three examinations showed no free HCl, with from 10 to 15 combined HCl. Slight food retention, no hypersecretion; microscopically, yeast cells, starch granules and blood cells. Passing of tube gave extraordinary hemorrhage of stomach mucosa.

X-ray bismuth examination showed no fill, no pathological incisura, freely movable hypotonic stomach with no tenderness along greater or lesser curvature, no delay in pyloric or duodenal filling, cap regular; slight six-hour retention, meal advanced to transverse colon; appendix not visible; no apparent ilial lagging.

Blood Examination: 7,800 whites, 85 per cent haemoglobin, 5,000,000 reds. No differential white count made.

Stool examination gave occult blood.

A fourth examination showed tenderness over the appendix and a diagnosis made. After appendectomy patient made a rapid recovery, with apparent relief from gastric and intestinal symptoms.

Case 3. E. A. B., age 68, Nebraskan, contractor and carpenter, farmer for many years. Family history negative; personal, hard worker, no alcohol, no specific. Present trouble began four years ago with hurting in the epigastrium. Would have to sit down when going upstairs at his home because of hurting in breast. Three years ago went to Florida for stomach trouble which gradually passed away, although conscious of epi-

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gastric pain on exertion. December, 1913, chopping down tree made epigastric hurting return.

January, 1914, tar-colored hemorrhage from bowels for five days, became extremely weak with constant pain in the pit of stomach and tenderness on pressure. Got about after two months of tonic treatment and rest.

April 30, 1914, after having bored thirty-five holes with a brace and bit through terra cotta, had another spell of bleeding, continuing until May 5th, when he first came to us for examination. He was very weak, dizzy, yellowish almost to cachexia. He was put to bed and treated for a gastro-intestinal hemorrhage. Temperature 97.6, pulse 110. He said, at this time, that his stomach trouble was in spells, following meals; had eaten something before the next meal to feel better; had lost five pounds in weight; no appetite; has craved "sweets" for years; liquids or solids make no difference; pain and discomfort in epigastrium whenever he moves about, radiates along the right ribs if anywhere, increased on movement. A large meal distresses; "But, I stop short," he said. "I have learned that." Sometimes belches gas, but never has vomited nor been sick at stomach; has always been constipated, using two enemas a day for twenty years; has noticed a tarry, black stool occasionally for the past ten years, worse January and May, 1914. The chief symptoms of complaint were epigastric pain on movement, occasional hemorrhage from bowels and epigastric tenderness.

Blood examination gave haemoglobin 30, 2,005 whites, 1,200,000 reds; smear showed no variation in size of reds, but granular degeneration, deficient cell rings and crescents. Gastric contents after test meal, no retention, small amount filtrate and residue, no free HCl, 20 combined HCl; microscopically yeast cells, epithelium, starch and long bacilli (Boas-Oppler?). The general examination showed a dry, rough skin, pale mucous membranes, cachectic color; few soft murmurs over heart; lungs, kidneys, spleen, pelvis negative; knee jerks normal; tongue coated white. Abdomen: tenderness extreme at sternal notch, gradually lessening down to umbilicus and toward the right epigastrium; very slight tenderness in left lower quadrant, no tenderness in right hypogastrium. Because of rectal trouble we made a proctoscopic and sigmoidoscopic examination showing a redundant, indurated rectum from which a section was removed and a diagnosis made of "dense, fibrous tissue covered by squamous epithelium, no evidences of malignancy or tuberculosis."

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Two months later at office blood count showed 50 per cent haemoglobin, 4,000 whites and 2,080,000 reds. X-ray bismuth examination made demonstrated a freely movable steer's horn, hypotonic stomach with no fill nor incisura; no tenderness along greater and only slight along lesser curvature.

Our diagnosis was achlorhydria hemorrhagica gastrica from gastro-intestinal ulceration probably gastric. He was advised to continue his tonic treatment for a longer period, when it would be safer to make an exploratory examination surgically. Some weeks later, unknown to us, he was advised to go to one of the large clinics where an exploratory operation was performed and a cystic appendix removed. He is fast recovering his color and normal condition.

Resume: The first case gives a picture of youth and indigestion, the second of middle age and nervous dyspepsia, the third of declining strength and vigor with a possible cachexia, all with varying degrees of gastro-intestinal hemorrhages, no free hydrochloric acid, and marked gastric disturbances, yet the pathology in every case lay in the caecal tail that too often wags the man.

Boiling Water Injections for Hyperthyroidism

Further experimental and clinical observations have convinced Porter that injections of boiling water into the glad should be substituted for the so-called medical treatment in patients with small thyroids and moderate symptoms of hyperthyroidism. This method is also peculiarly well adapted to the treatment of patients with moderate or severe symptoms and relatively small glands and especially to cases wherein the hyperplasia is circumscribed. It is therefore well adapted to the treatment of patients who have had a lobectomy done and are still suffering from symptoms of hyperthyroidism with hypertrophy of the remaining lobe. Patients with large goiters and extreme symptoms of hyperthyroidism should be treated wtih the injections until they become safe surgical risks and then have the gland removed. Boiling water injections are not recommended in non-toxic goiter. In such cases, as in patients with large goiters and toxic symptoms, but who are good surgical risks, thyroidectomy should be the chosen method of treatment. In substernal hyperactive goiters the removal of which would be hazardous, boiling water injections under guidance of the eye should be tried.

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ABSTRACTS

Sodium Fluoride for Insects

Means, passed assistant surgeon U. S. S. Cincinnati, states that at one time the storerooms and pantries became infested with roaches, and the ordinary insect powders seemed to have no effect on them. Sodium flouride was then used with marked result. Not only were the roaches killed, but also the ordinary black beetle that is found with the roaches.—U. S. Naval Medical Bulletin, July, 1914.

Ortizon Pencils

By J. Ruhemann in Deut. Med. Woch.)

These consist of a solid compound of hydrogen peroxide with urea; the pencils on becoming moistened slowly liberate the peroxide. They are made in several sizes. The author has found them of service in the treatment of deep infected wounds resulting from bullets, and of sinuses and fistulous tracts in which it is impossible to accomplish thorough cleansing by means of irrigations.

Electricity in Intestinal Stasis

Frank R. Starkey in the Medical Record for January 9, 1915, states that he has obtained and seen others obtain "splendid results" in intestinal stasis from the application of a mild, rapid sinusoidal current over the seventh and eighth dorsal vertebrae. The ptosis is markedly diminished and "one's treatment can be followed very beautifully by daily fluoroscopic studies of the stomach and intestines." He has seen them raised to a normal position in a remarkably short time, where there are no adhesions to bind them down. The effect of this treatment is lasting. The period required for emptying the ileum is distinctly shortened.

Are We Exaggerating the Dangers of High Pressure?

(By Tom A. Williams, M.B., C.M., Edin., Washington, D. C.)

High arterial tension is not itself a great danger, but the agent which produces it is. The author attributes it to hyperproteosis; and the cause of this is the failure of the organism to deal with an excess of protein. Cases are reported showing the efficacy of treatment which limits the proteins and increases

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metabolism by proper dietary means. Not all the cases show arterio-sclerosis, or high blood pressure. Vertigo, paresthesia, lumbago, recurrent headache or a thick dull feeling with incapacity to concentrate, or wakefulness and irritability, or melancholy may be the chief signs. Alcohol is of little importance in the etiology, except in cases where it produces hepatic or renal insufficiency. Any pressure above 120 is abnormal, even though usual in older people. Anxiety and strain are merely subsidiary factors.—The Critic and Guide, November, 1914.

Effusions, Etc., Share in Circulation

Scheel injected 0.10 gm. of methylene blue into the pleural effusion of a woman with severe valvular disease. The urine voided the next day and for seven more days was highly colored by the stain, showing that the pleurall effusion participates in the circulation, even when it is impaired as seriously as in this case. This assumption was further confirmed by the discovery that the edema fluid in the legs was also tinted by the stain. In other patients similar tests were made with 1 gm. hexamethylenamin by the mouth and with urea, showing that each passes into the edema and pleural effusion in a very few hours. A dropsical accumulation therefore must be regarded as a flowing stream instead of a stagnant pond.—J. A. M. A.

An Old Trick

Below we print, as a matter of interest to the profession, comments from the Ord Weekly Journal of February 4th, 1915, on the notorious case of a lot of traveling doctors against the editor of the Journal, Mr. Davis, who, it will be remembered, exposed their practices in his paper when they visited Ord, with the result of a case against him. The postponement and very often abandonment of such cases is an old trick of quacks—which brings them much notoriety—the kind of advertising they highly value because of its inexpensiveness:

TRIAL FOR DAMAGES POSTPONED FOR A YEAR

Doctors Buck and Loeffler Suit Against Journal Editor Postponed.

The traveling doctors who brought suit in federal court, charging that the Journal editor had injured their collective reputations to the extent of $50,000, have decided not to push their cases at the present term of court being held at Grand Island. Whether they will dismiss the action or not or whether

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they mean to allow the matter to hang fire and be a source of continued annoyance to Mr. Davis is not known except to themselves and their attorneys. The cases were filed on March of last year and came as a great surprise to the Journal publisher. It gave him a great deal of unfavorable publicity and caused him considerable expense and uneasiness, and he went to some pains to get the past history of the complaining "doctors" and to find out what their more recent record had been. He has interviewed more than a hundred of their dissatisfied patients and secured many affidavits. He now has a right to feel provoked and injured that the case must hang fire until another term of the federal court.

Quinin After Operation

A. Bonnot, St. Louis (Journal A. M. A., Jan. 9, 1915), gives his experience with the use of rectal injections of muriate of quinin after operative procedure. He first noticed the good effects in a case of appendicitis in which he had instructed the nurse to give the patient 10 grains of quinin muriate every six hours until the patient was able to take it by the mouth. The nausea and vomiting, gas pains, backache and post-operative thirst were lacking in the patient and he has since used it in later laparotomies with strikingly good results. In all cases, the postoperative thirst was much retarded, gas pains were lacking in nineteen cases out of twenty, and in none was there the usual backache. In only four cases was nausea and vomiting pronounced, in ten there was none, and in six it was only slight. Dr. Willis Young of St. Louis has also used this method with similar results.

Electric Treatment of Aneurysms

Valladares (Brazil Medico) has somewhat modified the so-called Brazilian method of treating aneurysms by application of the positive pole of a continuous or galvanic current. Instead of relying exclusively on the coagulating action of the positive pole, he enhances the action of the electricity by magnifying the interpolar transcutaneous voltaisation, as he calls it. Both electrodes should be of the same size and as large as the aneurysm to be treated. The electrodes can be changed about so that the skin does not suffer at any point from too long application. As the electrodes are of equal size, this permits the use of stronger currents. Electric treatment of aneurysms is regarded as a triumph of Brazilian medicine, and it is hoped that

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this modification of it will deprive it of all its previous drawbacks.

Action of Drugs on Pulmonary Artery

The action of a large number of drugs on strips and rings of surviving pulmonary arteries was studied by Macht. Epinephrin causes a powerful constriction of the pulmonary artery. After ergotoxin and a number of other drugs, the action of epinephrin on the isolated artery is inhibited. These observations speak strongly in favor of a vasomotor supply of the pulmonary artery. Of the digitalis bodies, all except digitonin produce constriction. The latter causes a dilatation of the pulmonary ring. The nitrites were found to produce a constriction of the pulmonary artery. It is suggested that this anomalous action of the nitrites is due to the pulmonary artery being richly supplied for the most part with vasoconstrictor nerve terminals. This action of the nitrites is corroborated by other experimental and clinical data, and points to a rational method of treating hemoptysis.—Jour. Pharmacol and Experiment. Therap.

Armies of Slaughter and the Army of Prevention

We shudder at the needless slaughter of the brave young fellows—allies and foes alike—but think of the slaughter which goes on in our homes, just as cruel as, often more cruel than, that of the battlefield! Tuberculosis alone will kill ten times as many this year in Great Britain as will die abroad for their country. Comparing the death rate in England today with that of fifty years ago we may say that, as a result of the work of the other army, more will be saved from death by enteric fever in 1914 than will be killed this year in the war. Eberth's Bacillus typhosus will kill in 1914 in the United States more than will German shrapnel and bullets in France and Russia. Moving in silence, the great army of sanitation, with a general staff and leaders of all lands and languages, claims allegiance only to humanity. In war it has not often fought winning campaigns, but the new knowledge is full of such promise that even the vanquished may be victors.—Sir W. Osler in British Medical Journal.

A Reward of Persistence

The great majority of oculists, including the undersigned, make a practice, when a patient with a piece of steel in the vitreous comes in, of trying the giant magnet eight or ten times and if this does not bring the steel forward into the anterior chamber, an attempt is made to loosen the steel with an instru-

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ment introduced into the eye if the steel can be seen, or by introducing a small magnet tip through a scleral opening into the immediate vicinity of the steel. That greater persistence with the giant magnet should probably be the rule is indicated by the experience of Lewitus, who, in such a case (Klin. Monatsbl. f. Augenheilk., July, 1914, p. 244), succeeded in breaking up the attachments of the steel and bringing it safely into the anterior chamber from which it was easily removed, by repeately making and breaking the current to the giant magnet for a full hour. Lewitus, to be sure, would undoubtedly not have been so persevering if he had not been able to see with the aid of transillumination, that the steel moved a little every time the current was turned on. Nevertheless the case may well encourage the rest of us even when we can not see the steel to persist in our attempts with the giant magnet for a much longer time than is customary. GIFFORD (Omaha).

Heat, Humidity and Working Power

What constitutes a vitiated atmosphere, and wherein are the depressing effects of "bad" air to be found? Of late, temperature and humidity rather than abnormal quantities of the respired gases, carbon dioxid and oxygen, or the presence of harmful expired organic products of respiration, have been held responsible for the untoward consequences of living under conditions of poor ventilation. Drs. Lee and Scott, of the College of Physicians and Surgeons and Columbia university, have recently reported definite objective signs of physical inefficiency in individuals subjected to an atmosphere of high humidity and high temperature. Measurements were made on the working capacity, that is, the total amount of work which excised muscles of animals are capable of doing before exhaustion sets in. The subjects were kept, to cite a specific illustration, at 21 C (69.8 F), with an approximate humidity of 54 per cent, in one case, and at 33 C. (91.4 F.), with a humidity of 89 per cent, in the other. The contrasts here quoted represented the distinctions between comfortable atmospheric conditions and the air of a hot, humid summer day. As an outcome there was a marked diminution in both the amount of work performed and the period of working power under the influence of high temperature and humidity. Under these conditions, furthermore, the body temperature also rose somewhat. The facts thus cited in the opinion of The Journal of the American Medical Association confirm by the unbiased testimony of direct experiment what the sensations and psychic responses of man have long since intimated.

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The Sex of the Insane

Of approximately every five hundred persons in the United States in 1910, there was one an inmate of an insane asylum. The exact figures expressed in a recent report[1] state that in a typical community of 200,000 persons, equally divided as to sex, 208 of the males and 200 of the females would be found in the insane asylums. In the course of a year, 72 males and 60 females would be admitted to the asylums. In 1880 the total number of inmates in insane asylums in the United States included 20,635 males and 20,307 females. Thirty years later the number of male inmates had increased to 98,695, and the number of female inmates to 80,096. The excess of men among admissions in 1910 indicated a still further increase in the proportion, namely, 128 males to 100 females. An analysis of these admissions as to the specific forms of insanity involved brings to light the interesting fact that if alcoholic psychosis and general paralysis are deucted, the proportion of the sexes is practically the same. The diseases mentioned would seem to be those which, generally, are the result of dissipation. Alcohol and syphilis again establish their superiority as man's most dangerous allied foes.—J. A. M. A.

Transference of Pain in Genital Diseases

Diseases of the female genitalia are accompanied by reflex pains in various locations, says J. B. Porchownik (Monat. f. Geburt, u. Gyn., 1913, xxvii, 719). The sympathetic plexuses of the uterus and adnexa are located in the latter. The reflex pains in the socalled endometritis dolorosa are especially severe, but they also occur in oophoritis, retroflexion of the uterus, etc. These pains are caused by anastomoses between the plexus of the body of the uterus and the first and second spinal nerves from the sacrel plexus.

Pain in the bladder, the so-called cystospasm, and in the kidneys and gall bladder are also explained by anastomoses of the sympathetic plexuses with each other and with the plexus of the body of the uterus. This also gives rise to the reflex cough (uterine cough of Auvarel). Attacks of neuralgic pain in the region suplied by the trifacial are interesting. Only certain areas of the skin of the face are painful, the so-called hyperalgesic zones. The irritation of the genital organs is transferred through the solar plexus to the cervical plexus of the sympathetic, and from there to the posterior roots of the spinal nerves and the trifacial.—(Surg., Gyn. & Obst., April, 1914.

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Blood Washed and Returned to the Body

Iurevich and Rosenberg experimented on rabbits and demonstrated that the blood can be removed from the body, thoroughly washed out and reintroduced into the animal's system without causing any appreciable morbid symptoms. The blood was taken from the carotid artery, drawn into test-tubes containing a 1.5 per cent. solution of sodium citrate to prevent coagulation, and up to one-half of the total amount of the animal's blood was thus withdrawn. It was then centrifuged for about ten minutes; the plasma was removed and replaced with normal salt solution, and the blood was again centrifuged, repeating these procedures three times if necessary. Then the thoroughly centrifuged and washed blood was warmed (to 38 or 40 C.) and injected back into the rabbits, through a vein in the ear. In some they immediately replaced the amount of the withdrawn blood by a corresponding amount of normal salt solution. They found that only a small portion of the red blood-cells became destroyed, the majority remaining intact, even when the blood was kept outside the body for two or three hours. Thus the stability of the red blood-cells is very great, and in cases of toxemia, when the blood is saturated with toxic substances, blood-letting followed by reintroduction into the vascular system of the blood that had been removed and washed ought to be of great clinical value. Experiments along these lines are now being conducted.—Russky Vrach.

Cholelithiasis and the Gastric Juice

(Kgl. Rat. Dr. Ludwig von Aldor, Carlsbad Wien. Kl. Wochschr. Nov. 18, 1914.)

1. Cholelithiasis may coexist with hyperacidity or normal acidity, or may be found in conjunction with sub or anacidity. Every cholelithiasis must be treated according to the stomach findings.

Sub or anacidity may have resulted from a chronic gastritis or be caused by a cholelithiasis. The gall bladder is not a simple reservoir, but it influences the gastric secretion. The extirpation of the gall bladder will cause irreparable disturbance of secretion, especially sub or anacidity.

2. Sub or anacidity due to gastritis is accompanied by an increased secretion of mucous. Functional tests at great intervals show a progressive decrease in the secretions of the

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stomach, as for instance a decrease in 6 years of free hydrochloric acid from 60 to 30 and total acidity from 80 to 50.

These patients do not have such violent colics and are never free of dyspepsia or light liver disturbances even in the intervals. A mistake in the diet causes colic. The infection has descended from the stomach to the biliary ducts.

Whenever a sub or anacidity is encountered without other symptoms of a chronic gastritis, a diagnosis of a severe derangement in the biliary system, especially an atrophy of the gall bladder or stenosis of the gall ducts must be made as the cause of the sub or anacidity.

Ascending infections of the gall bladder (coli bacillus) and gall ducts cause severe and frequent colics, the intervals of which are free of symptoms. In this condition we frequently find catarrh of the small and large intestines, which often causes gastric disturbances secondarily.

3. Therapeutically we must treat cases with sub or anacidity differently from those with normal or hyperacidity.

The diet in the anacid cases must be of an ovo-vegetable nature (Albu.). Carlsbad water given hot before meals must not exceed 100 cc. per os. Large amounts of water are indicated in cholelithiasis and in these cases are given per rectum, daily 1 liter at 45 to 60 degrees centigrade.

Hydrochloric acid 25 to 30 drops in one-half glassful of raspberry water thirty minutes after meals. The hydrochloric acid acts as an antiferment, antiseptic and excites the pancreas secretion. This is the principal action because the hydrochloric acid deficit cannot be replaced by medication (1 part hydrochloric acid only digests 18 parts of albumen. (Honigman.)

Gastric lavage is useful, but only when there is an abundant secretion of mucous.

Leukemia

Martelli (Reforma Medica) records the details of twelve cases of leukemic myelosis, five of leukemic lymphosis, two of leukanemia and five of what he calls prelukemia, comparing the findings and previous history. He inoculated numbers of laboratory animals with blood and tissues from the patients, but never succeeded in reproducing any affection resembling the original leukemia, etc. These negative results and the fact that contagion is not known or any focus where the disease is prevalent, all speak against the assumption of a specific germ for it. On the other hand, in nearly every one of his cases there was a

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history of some preceding infection or the patient was in a septicemic condition. Tuberculosis, syphilis, malaria, streptococcus or staphyloccoccus affections were known in most of the cases. There was also a predisposition evident in most, manifested by adenoids, unstable nervous system, or defective development. An additional factor was evident in some cases from a trauma, over-frequent pregnancies, etc. An ordinary toxic infectious affection occurring in the predisposed may lead to the changes characteristic of leukemia. Treatment and prevention should aim to restore normal conditions throughout, and thus counteract the tendency to abnormal metaplasia of the tissues involved. Benzol and Roentgen treatment do not act on the cause.

"Speeding Up" and Accidents

By far the larger number of industrial accidents occur at about 10 a. m. and 3 p. m. This fact is confirmed by the reports of two state boards, Washington and Massachusetts, which have secured rather careful records. As they represent the extremes of the country, the conclusions from their statistics would seem to be incontrovertible, though the fact is not what might naturally be expected. The state of Washington industrial commission says: "These results seem to disprove the theory that fatigue is the prominent cause of the accidents, because accidents are here shown to happen at the hours when the workmen are least fatigued." On the fatigue theory it might naturally be expected that most accidents would happen after 11 a. m. and 5 p. m. The actual hour of the high point of the curve of accidents shows how important are the facts and how necessary of proof the theories.

After much discussion, the tendency to speed up employment has been incriminated, as the predisposing condition for the occurrence of accidents. This desire comes over the workman when he is not yet fatigued, but has been employed for several hours. He starts the morning's work "cold," and as he warms to his work the danger of mischance because of haste becomes greater. Just when the speeding up reaches a climax in the morning hours, most accidents happen. The same thing is true in the afternoon. Workmen feel sluggish after their lunch, but after an hour of work warm up again, and by about 3 o'clock they are doing their most rapid work, and are at the same time more subject to accident.—Journal American Medical Association, February 6, 1915.

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Position of the Fetus

The head presentations are the rule in delivery at full term and about 97 per cent present the occiput. Many theories have been advanced to explain this fact, and the more accepted theory has been that it is due to the greater weight of the fetal head. Many objections have been raised to this explanation by high authorities, such as Duncan, Scanzoni, Sir James Simpson and Schatz. These are reviewed by C. G. Garnum, Groton, Conn. (Journal A. M. A., Feb. 6, 1915), who reports his own experiments made with fetuses at different stages of development, in a salt solution of such specific gravity that the fetus is freely suspended in it. His observations almost exactly duplicate those reported by Duncan; and comparing theme with those of Simpson, Schatz and Williams, showed that the head of the fetus has a higher specific gravity than the body; and the center of gravity in the uterus is nearer to the cephalic end. He does not deduce from this, however, that breech presentation ought to be the rule, and he gives his conclusions after studying the subject in its various lights and comparing the conditions with those in the lower animals, as follows: "I think it has been shown that the action of gravity contributes to the production of the cephalic presentation, and that the interpretation of Schatz' experiments was an error because of the manner in which the support was applied in those experiments. In support of the proposition that the action of gravity participates in the determination of the cephalic presentation, three main considerations have been brought forward: 1. The amount and distribution of the effective part of the weight of the fetus lying in the amniotic fluid. 2. The admitted contribution of the action of gravity to the production of the left occipito-anterior position, which is one of the most characteristic features of the cephalic presentation. 3. The very great probability that the action of gravity contributes to the production of the normal presentation and the normal position of the fetus in animals."

Disturbances of Motility in the Stomach

Prof. Dr. Winternitz (Halle), Deutsche med. Wochenschr. 1914: No. 20.

1. The normal stomach empties itself within six or seven hours after a test dinner and two hours after a test breakfast. Lavage tests for disturbances of motility are made after each of the respective hours have elapsed. After taking the Boas sup-

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per test, tea with milk and sugar, two buns with butter and cold meats, the stomach is washed out in the morning about twelve hours later.

2. Motor insufficiency of the first grade. Low grade disturbance of motility is present if seven hours after a test dinner a quantity of remnants is still found, but stomach empty the next morning. A motor insufficiency of the second grade if the stomach is not found empty after twelve hours.

3. Ectasia of the stomach and its causes. Motor insufficiency and ectasia are not identical. The latter may be present even if the stomach empties itself in a given time (Megalogastria). This will not be considered here. Contrary to this we have a simple atony which manifests itself in a retarded evacuation of the stomach contents, without a co-existant ectasia, a simple gastric debility. This condition is purely functional.

A stomach of normal size when empty may become dilated when filled, a condition which may become persistent and then be classified as the atonic ectasic form.

Atony is generally combined with hyperacidity and hypersecretion. Most frequently the extasia is not caused by simple atony or weak peristalsis, but by pyloric stenosis. (Stenotic ectasia).

After a bismuth meal the X-ray shows in a normal stomach a shadow up to the pars cardica and in atony a shadow in the caudal sack with collapsed pars media.

4. The diet in motor insufficiency must strive to spare the organ as much as possible and therefore a dry diet appears most suitable or a semi-solid diet which is easier to carry out in practice, although not as efficient.

The state of the secretions must also be considered in prescribing the diet and above all an overloading of the stomach must be prevented.

Small meals every two to three hours and never more than one-fourth liter of fluids at a time. (Milk, water, weak tea and coffee, no drinks containing carbonic acid gas or alcohol).

Treat patients individually and not after a prescribed diet list and control the diet by frequent stomach washings.

5. Motor insufficiency with almost always combined hyperacidity. In these cases fats are not tolerated, but tender chopped or cooked lean beef, veal or poultry are well tolerated. Butter, cream and eggs are indicated. Buttered toast, potatoes, tender vegetables only mashed or in puree form. Cocoa containing the fat is preferable to the cocoa minus the fat because appar-

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ently the fat exerts a soothing effect. Carbohydrates and heavy fats are to be reduced in hyperacidity because they excite secretion and cause thirst.

To be recommended is Cohnheim's Oil Treatment, that is prescribing cream and olive oil after lavage of the stomach.

6. Motor insufficiency with subacidity requires a diet of a fluid or soft consistency and rich in carbohydrates. Rice, cream of wheat, potato puree, cereal soups, tender vegetable purees, puddings with fruit juices.

7. Other therapeutic measures in motor insufficiency. Stomach lavage. Rest in the right recumbent posture after eating facilitates the emptying of the stomach in pure atonic forms, or in strong patients exercise attains the same end.

Bandages, especially plaster bandages to support the stomach. Electrotherapy, hydrotherapy, massage, vibration and gymnastics.

8. Medical therapeutics.

1. In hyperacidity. Alkalies and strychnine.

Rx Ext. Nucis Vomicae.....0.02
Mag. Ustae.
Bismuth Salicyl. aa.....0.5
M. Div. in pulv. No. XX.

Sig.—One powder three times daily after meals.

Or 2. In fermentation and subacidity give hydrochloric acid and caps. Creosoti 0.1.

Sig.—One capsule three times daily after meals.

Or Rx Acidi Carbolici 3.0
Mass. pil ad pil No. L.

Sig.—One pill three times daily after meals.

Or Rx Resorcin resublim 0.1
Saccharin 0.02
Pulv. Cocoa 0.4
M. div. in pulv. No. XX.

Sig.—One powder three times a day thirty minutes before meals.

In spasms of the pylorus give belladonnae.

Rx Ext. Belladonnae 0.5
Sod. Bicard.
Mag. Ustae aa.....25.0

M. D. Sig.—One teaspoonful two or three times daily before meals.

9. Stomach lavage is excellent in relieving the stomach of the stagnant and fermenting contents and insures intervals of

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rest. After the first few stomach washings the patients feel rejuvenated and the symptoms of fullness, pressure and heart burn disappear.

In performing lavage one may use lukewarm water, with the addition of one teaspoonful of salicylic or boric acid to the liter or 0.5 per cent hydrogen peroxide, or either carlsbad salts, common solt or calcium carbonate. Lavage daily, but not to excess. Lavage after supper is beneficial in that the patient as a rule has a restful night and the peristalis of the stomach is reduced to a minimum.

In conjunction with the stomach washings the use of two or three rectal injections with normal salt solutions up to one-third liter each time.

Fleiner says: "A stomach that is not empty in the morning before breakfast must be washed out." This is also the opinion of Winternitz in spite of the contrary opinion of other authors. Even stenotic insufficiency can be materially benefited by lavage, although the benefit is only temporary and relative.

10. Operative procedures generally become necessary in stenotic insufficiency, and the relief is more pronounced the earlier the operation is carried out.

In stenotic insufficiency of the second grade, also in benign stenosis the resection of the pylorus is to be recommended if only for carcinoma prophylaxis. It relieves the symptoms of benign and temporarily the malignant cases.

In the third grade gastroenterostomy is indicated.

Twilight Sleep

(By John Osborn Polak.)

Total amnesia and analgesia are procurable in at least 90 per cent of cases and the dangers to the child are much less than usually stated by the opponents of the method. Many children do not breathe for a few moments after birth, but it is very rare to encounter one which is truly asphyxiated so as to need artificial aid for the establishment of respiration. The particular advantages of the method, aside from the relief of suffering, lie in the fact that the analgesia permits the cervical dilatation to proceed more rapidly, actually shortening this stage of labor; this also holds true of the relaxation and dilatation of the pelvic soft parts and the perineum; by relieving the mother of the exhaustion of ordinary labor and its attendant suffering, there is less tendency for the development of uterine inertia. This is all particularly true of the nervous woman with

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her first child. The great danger to the child seems to lie in the administration of too large or too frequent doses of morphine or narcophin, but scopolamine can be repeated as needed.—New York Medical Journal.

Amputations in War Surgery

M. Fitzmaurice-Kelly calls attention to a method of amputation which he has suggested and which is now widely practiced in some of the military hospitals in France. The method consists in a simple circular division of all the tissues, including the bones, at the same level, and that level the lowest possible. The skin is divided by a circular sweep, the muscles are divided at the level to which the skin retracts, and the bone is then sawed at the same level. The bleeding points are secured and tied, the nerves pulled down and cut short, and a dressing is then applied to the raw surface of the stump. The advantages claimed for the method are: (1) Economy of tissue. The amputation is performed at the lowest level at which a flap could be cut, or even lower, and all recoverable tissue is thus preserved. (2) It is applicable to otherwise hopeless cases, such as wounds or gangrene at the root of the limbs, and in these cases carries a much better prognosis than disarticulation at the hip or shoulder joint. (3) It is very rapidly done, and there is very little shock. (4) The surface from which septic absorption can occur is the least possible, and the drainage is free. (5) The nutrition of the stump is unimpaired; in this respect its advantage over a flap amputation is obvious. (6) It is so simple that it is said to be within the range of every one and not to need an experienced surgeon for its performance.—London Lancet.

Magnesium Sulphate Treatment of Tetanus

Weintraud (Berl. klin. Wochenschr., No. 42, 1914). The German journals devote much space to the treatment of tetanus following wounds received in the trenches. Most of the writers express themselves favorably in regard to the treatment suggested nearly eight years ago by Meltzer and Auer of the Rockefeller Institute. It consists in the intraspinous injection of a 25 per cent solution of magnesium sulphate, in a dose of 1 c.cm. for every 10 kg. of body weight. Kocher prefers to give 5-10 c.cm. of a 15 per cent solution after withdrawing an equal quantity of spinal fluid. The results have been satisfactory symptomatically. The patient is kept much more quiet than with other methods of treatment and death through exhaustion

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is less imminent. In addition to the intraspinous injections 15-20 c.cm. of a 20 per cent solution may be injected hypodermically several times daily. In no case, however, must the magnesium sulphate be given intravenously as immediate death may ensue. The writer also advocates the use of tetanus antitoxin both hypodermically and therapeutically and the treatment of the site of infection by means of hydrogen perxoide.

The Newer Experimental Medicine

"It is one of the merits of the modern experimental medicine, which has departed from exclusive attendance at the bedside in order to enter the laboratories of the physiologist, physiologic chemist, pathologist, and pharmacologist, that it is rapidly learning to imitate human disease for purposes of study. A glance at the journals of scientific medicine of the present," says The Journal of the American Medical Association, "discloses not merely the conventional recitals of clinical statistics, of case histories and necropsy reports, but also a newer type of contributions which are concerned with the effects of definite lesions induced according to a preconceived plan, or of pathologic states of organs or perverted metabolic processes initiated at will. Experimental injuries to the pancreas in animals have made possible the imitation of many features of human diabetes; operative interference with the organs within the cranial cavity has furnished a long-desired opportunity to study hitherto obscure diseases involving the pituitary gland and the cerebro-spinal system; surgical obstruction of the gastro-enteric tract has duplicated the conditions of intestinal stagnation and so-called alimentary toxemia so as to reproduce symptoms of unexplained origin; intoxications with various drugs have furnished illustrations of disturbed nutrition associated both with upsets of chemical processes in the body and with the consequences of induced degenerative changes in important organs. The catalogue of these and numerous other instances of the distinctly modern method of approaching the problems of the damaged organism becomes the more impressive as one contemplates how recent such helps to the interpretation of disease really are. Lee has reminded us that it is scarcely more than half a century since the demonstrative teaching of Dalton, who came to the College of Physicians and Surgeons at New York in 1854, fresh from the inspiring laboratory of Claude Bernard, created much enthusiasm and inaugurated a new era for American students of medicine."

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NEBRASKA NOTES AND NEWS

Dr. McFadden is a new physician in Greenwood, Neb.

Dr. T. S. Kelly of Beatrice has removed to Sioux City, Ia.

Dr. J. C. Storkan of Lincoln, Neb., has recently located in Uehling, Neb.

Dr. E. Ardiel of Calgary, Canada, is a new physician located in St. Paul, Neb.

Dr. Telleson, coming from Wynot, Neb., is reported to have removed to Maskell.

Dr. Stanley Clements of Hay Springs, Neb., has recently removed to Neligh, Neb.

Dr. Homer F. Fort, coming from Omaha, has located in Nelson, Neb., quite recently.

Dr. J. E. Barrett of Lawrence, Neb., died very suddenly at a hospital in Lincoln on January 10th. He had been ill for a considerable time.

Dr. Harman of St. Joseph, Mo., is a new physician reported to have located in Table Rock, Neb.

Dr. Fletcher of Thurston, Neb., has gone to Chicago, where he is doing post graduate work in a hospital.

Dr. H. F. Fort of Uehling, Neb., has removed to Alliance, Neb., where he will enter in the practice of medicine.

Dr. Alfred J. Knight and Miss Pauline Poledna of Howells, Neb., were married at the home of the bride January 12th.

Dr. G. W. Connelly of Humboldt, Neb., has removed to Fort Morgan, Colo., where he intends to make his future home.

Dr. Nesbit and wife of Tekamah, Neb., have gone to California where they will spend the winter months enjoying that milder climate.

Dr. J. S. Schroeder of West Point, Neb., and Miss Mabel E. Hawk of Alton, Ill., were married at the home of the bride on December 28, 1914. Their home will be in West Point.

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Dr. R. R. Seasongood of Platte Center, Neb., has purchased the practice of Dr. Fletcher of Thurston, Neb., and has located in that town.

Dr. B. M. McIntyre of Winside, Neb., recently underwent a serious operation in a hospital at Sioux City, but at last reports was convalescing nicely.

Dr. and Mrs. B. F. Farley of York, Neb., celebrated their golden wedding anniversary on February 8th. Their three daughters conducted the affair.

The Mary Lanning hospital of Hastings, Neb., was opened to the public January 21st. This hospital, built in memory of Mr. Lanning's daughter, Miss Mary Lanning, who died in 1910, is one of the most complete in its construction and equipment of any hospital in the state of Nebraska. It will be conducted by a thoroughly equipped staff of physicians and nurses. It has a capacity of about fifty beds.

GENERAL NOTES AND NEWS

Lieutenant Colonel Herbert S. Birkett, M. D., dean of the medical faculty of McGill University, Montreal, is to be in command of the general hospital offered by McGill University for service in France.

About the middle of December it was decided to increase the staff of the Canadian nurses now in Great Britain ,and it is expected that the 75 to be chosen from about 2,000 applicants will be sent soon.

Dr. Caroline Hedger, formerly in charge of the infant welfare work in Chicago, and her friend and assistant, Miss Janet Hall, have left Chicago for Belgium to take charge of the work of caring for thousands of homeless children under the Belgium Red Cross.

Fifty physicians of Detroit, who are members of the board of commerce, have volunteered to donate their services free in destitute cases discovered by the board. The Florence Crittenden Home has been placed at the disposal of the board for confinement cases.

We understand that a number of women doctors have applied to the French war office for permission to join the staffs in the base hospitals. One woman surgeon has already distinguished herself by the number of operations performed upon wounded soldiers.

Dr. Milton J. Rosenau, professor of preventive medicine at Harvard Medical School, has been appointed pathologist to the Massachusetts State Department of Health, and Dr. Eugene R. Kelly of Seattle has been made director of the department of communicable diseases.

In view of the fact that various ports in Italy have lately become foci of bubonic plague, the authorities in Naples have ordered that all ships must take strict precautions and use guards, etc., to prevent rats getting ashore from the ships. No ship can anchor less than five meters from the dock.

Dr. William H. Park has offered his resignation as dean of the New York University Medical College because of the ruling of the Department of Health that its department heads shall not hold administrative position elsewhere. Dr. Park is director of laboratories. He will retain his position as professor of bacteriology and hygiene in the college.

Mr. Ralph W. Wheelock, of the state board of control of Minnesota, makes the admirable suggestion that the more patients that go voluntarily to our state hospitals for the treatment of mental disorders the fewer will be the legal commitments. As both care and treatment are free, the medical profession should consider this matter carefully.

It is reported from Macomb, Ill., that the physicians of that city have rented a portion of an office building and are attempting to work on a co-operation basis, the instruments of each to be of service to others. They will also place the knowledge of each at the disposal of others, and patients will enjoy the advice and consultation of all, at no additional expense.

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Communicable diseases in Pennsylvania during 1914 were 50,000 less than the number in 1913, according to a statement issued December 31 by Dr. Samuel G. Dixon, commissioner of health. Typhoid fever decreased 70 per cent. The general death rate was only 14.1 per 1,000 inhabitants. Tuberculosis was reduced, and cancer was the only disease which showed an increase.

An interesting story comes from Paris: A mechanic at certain motor works near Paris was caught in the machinery and was bleeding to death. When the message was telephoned into Paris, a doctor seized his instruments, took the observation seat on a military biplane, and reached the motor works, eight miles distant, in five minutes. He at once stopped the bleeding and saved the man's life.

The coroner of Chicago, in an effort to prevent suicide, and relieve despondency, hit upon the plan of placing on coroner's juries only those who were in need. Since September 1, about 7,500 men who were out of employment have sat on these juries and collected their dollar a day. More than twenty men have already testified that they were on the verge of suicid before they were saved by this plan.

George Bernard Shaw, the famous Irish author whose writings have caused a storm in England, states in a recent article: "The truth is that of all the belligerents, Belgium and Belgium alone is innocent of all warlike designs. * * * There is absolutely nothing between them and starvation except the contributions of the world." The foregoing, of course, applies to physicians and their families as well as to other citizens of Belgium.

Beginning January 11, twenty-four restaurants were started in the public schools of the greater city of New York. Superintendent Maxwell announces that he has at present $9,000 with which to start the project, and Andrew Carnegie has promised $2,000 provided an additional $10,000 is raised. A portion of any article on the menu will be furnished to a pupil at one cent and free tickets will be distributed to those unable to pay.

The Harvard Medical School will send a party of trained surgeons and helpers to Paris on April 1 to work in the American hospital if $10,000 can be raised before that date. Dean Edward H. Bradford is anxious to have the plan put into execution, for he believes that other schools in the United States will follow the example of the Harvard medical men, and thus start a chain of helpers toward Paris to give their labors to the war sufferers. The Harvard party will include two resident surgeons, three internes, two operating nurses and two anesthetists, and they will remain in Paris for three months of work at the American hospital before they return to give up their places to other medical volunteers from this country.

....A MANUAL OF DISEASES OF THE NOSE, THROAT AND EAR.....

Third Edition, Thoroughly Revised.

By E. B. Gleason, M. D., Professor of Otology in the Medico-Chirurgical College, Philadelphia. Third edition, thoroughly revised. 12 mo. of 590 pages, 223 illustrations. Philadelphia and London... W. B. Saunders Company, 1914. Cloth $2.50 net.

A book of some 590 pages written in a compact, concise style, well balanced in thought and applicable especially to students.

The essential fundamentals of the fields covered in the book are very well displayed, and although the book is not intended as a reference work, yet very few essential details are missing. Especially good is the formulary at the back, in which are many new innovations, in so far as the ordinary text book usually considers.

All in all, the book is a very creditable output, and should be well considered when building up a handy working library.

W. P. WHERRY (Omaha.)

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SOCIETY MATTERS

ADAMS COUNTY MEDICAL SOCIETY

At the annual meeting of the Adams County Medical Society at Hastings the following officers were elected:

President, Dr. M. W. Baxter, Ingliside; secretary-treasurer, Dr. E. B. Hamel, Hastings.

SAUNDERS COUNTY MEDICAL SOCIETY

At the annual meeting of the Saunders County Medical Society the following officers were elected:

President, Dr. Joseph E. Kasper, Prague; vice president, Dr. J. E. Koerber, Yutan; secretary, Dr. M. A. Quincy, Ashland; treasurer, Dr. A. S. von Mansfelde, Ashland; delegate, Dr. E. O. Weber, Wahoo; alternate delegate, Dr. J. F. Lauvetz, Wahoo; censor, Dr. Frank Tornholm, Wahoo.

HALL COUNTY MEDICAL SOCIETY

At the annual meeting of the Hall County Medical Society in Grand Island on February 3d, the following officers were elected to serve for the ensuing year:

President, Dr. A. H. Farnsworth, Grand Island; vice president, Dr. C. P. Fordyce, Burkette; secretary-treasurer, Dr. E. G. Johnson, Grand Island; delegate, Dr. B. R. McGroth, Grand Island; board of censors, Dr. D. H. Carson, Dr. B. R. McGrath, Dr. Leo Phelan.

TWELFTH COUNCILOR DISTRICT MEETING

A meeting of the physicians of the Twelfth Councillor District was called by the Councillor to convene in Alliance January 19th. The response from the physicians of the district was very gratifying and a good program was prepared. Physicians were in attendance from as far as Guernsey and Torrington, Wyo., on the west and from Crawford on the north. Most of those from outside Alliance arrived about noon and the Box Butte Society had prepared to receive and entertain them. A good clinic was held during the afternoon, and many interesting cases were presented, examined and discussed. When the seven o'clock dinner hour arrived, all were taken to the Drake hotel, where a sumptuous five-course banquet was served, followed by after-dinner talks and stories—and good ones, too.

In the evening the scientific program was given, and excellent papers read by Dr. J. Stanley Welch and Dr. H. J. Lehnhoff of Lincoln, and Dr. George J. Hand of Alliance. Dr. J. W. Orr of Lincoln was also present and added much to the program by giving a talk on spinal curvature, and the work at the Orthopedic hospital. About midnight the meeting adjourned and many hurried for their trains and all the guests were unanimously agreed that the Alliance physicians are royal entertainers, and departed with many expressions of appreciation of their hospitality.

ALFRED J. STEWART,
Councilor of the Twelfth District.

STATE ASSOCIATION NOTES

The list of members who paid their 1915 dues during December, 1914, and January, 1915, is evidence of an increasing interest in our Association work. The following is our record for four years ending January 31, 1915:

1912—38 paid dues; none in the defense.
1913—82 paid dues; 16 in the defense.
1914—82 paid dues; 46 in the defense.
1915—241 paid dues; 241 in the defense.

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Our county secretaries are doing splendid work. For most of our members it is just as easy to pay in January as to wait for a few weeks or months, and prompt payment will obviate considerable work for the local secretary who has troubles and work enough without having to make a personal plea for your dues.

That our Councilors are awake to the importance of their official duties is becoming evident.

Members who were paid up in 1914 will automatically be dropped from our list if not paid up by March 31, 1915. Our national office has my roll for all the members reported to this office up to the 31st day of December, 1914. That list holds good until the 31st day of March, 1915, when a new roll will be mailed from this office to the national secretary, including only those who are paid up for this calendar year. The applicants asking for a place on our Scientific Program is already a greater number than we have had on this date in any preceding year. The outlook for a full program and large attendance at Hastings May 18, 19 and 20, 1915, is good. The final proof reading of our program will be given to the printers April 15th. This is necessary that we may get them mailed to the members, as our constitution and by-laws require, fifteen days prior to our annual session. We ask your co-operation in every way possible to make our next meeting the best one of our history.

JOSEPH M. AIKIN, State Secretary,
468 Brandeis Building, Omaha, Neb.

STATE BOARD OF HEALTH MEETINGS

Lincoln, Neb.—Board met at 9 p. m., at the Lincoln hotel, January 12, 1915. All members present.

Minutes of previous meeting read and approved.

The following applications for reciprocity were received and on motion licenses were ordered issued on completion of papers:

R. W. Murray from Missouri.
F. J. Parizek from North Dakota.
W. F. Ware from Iowa.
J. H. Hayes from Michigan.

The secretary reported having issued the following reciprocal endorsements:

James B. Hungate to Iowa.
H. J. Willey to California.
J. P. Bishop to Oklahoma.
A. F. Burkard to California.
F. M. Neville to Illinois.

The following applications for maternity homes were received and on motion licenses were ordered issued on the completion of applications.

Gertrude R. Smith, Omaha, Neb.
E. A. Hollingsworth, Beatrice, Neb.
Cora E. Sweasey, Milford, Neb.

Moved that we proceed to reorganize the board. Dr. Dodson was elected president; Dr. Carr, vice president; Dr. Cummings, secretary, and Dr. Burchard, treasurer.

On motion adjournment was taken.

Lincoln, Neb., January 15, 1915—Meeting called to order at 10:40 a. m. by Dr. Dodson, president. All members present.

Communications of Dr. Wild read and ordered placed on file.

The following resolution was introduced by Dr. Burchard and seconded by Dr. Dodson:

"Whereas, The legislature, at its 1913 session, authorized the establishment and equipment of a certain laboratory to be known as the State Bacteriological Laboratory of the State of Nebraska and placed the same under the supervision of the Board of Secretaries to the State Board of

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Health with expressed power to select a director of said laboratory and in pursuance of such explicit directions such laboratory was duly established and equipped and a director therefor named and recommended and duly employed in the person of one Dr. William F. Wild, and

"Whereas, It has come to our notice that Dr. William F. Wild, as such director, has become disgruntled, rebellious and disloyal to the Board, or body to whom by statute he owes his respect and allegiance, the conclusion is forced upon us that he has outgrown his usefulness to the state and that its best interests are not being conserved; therefore, be it

"Resolved, That Dr. William F. Wild be informed that his services are no longer desired and that he be directed to tender his resignation to take effect at once."

And on motion was adopted, Drs. Burchard, Dodson and Cummins voting aye; Dr. Carr voting no.

On motion adjournment was taken.

BELGIUM

A recent visitor to Belgium says of the desolation there: "No one who has not been to Belgium within the last five months can picture, can even dimly conceive that country's desolation.

"Wherever our ambulance cars went they met endless processions of refugees; endless, for the straight, flat Flemish roads are endless, and as far as your eye could see the stream of people was unbroken; endless, because the misery of Belgium is endless; the mind cannot grasp it or take it in.

"It was not flight; it was the vast, unending movement of a people crushed down by grief and weariness, pushed on by its own weight, by the ceaseless impact of its ruin.

"I saw six thousand refugees sleeping on straw in the Palais des Fetes, packed so tight on the floor of the immense hall that there was no standing room between any two of them.

"You could not believe what you saw: you were stunned as if you yourself had been crushed and numbed in the same casastrophe."

An American gentleman who saw the food and clothing put into the hold of the steamship, Lynorta, which took supplies, for the state of Virginia, to the Belgians, crossed the Atlantic on the ship and went into Belgium to watch the distribution of the articles among the people. He has returned and declares: First, that every pound of flour and every article of clothing sent from America by the Relief Commission is received by a Belgian; and second, that all who get such gifts are in dire need of them. Hunger seems to have broken down all class of distinctions in Belgium.

Captain Green, of the Steamship Batiscan which sailed with food from Philadelphia on December 6th, says that the suffering among the Belgian people cannot be exaggerated.

Linden W. Bates, manager of the Commission for Relief in Belgium, states that within a few months the bread lines in Belgium will be 2,500 miles long, which would reach from New York to Salt Lake City.

Physicians and their families have shared the common fate. Appeals for food, drugs, and clothing are numerous and urgent. The resources of your committee have been so limited that we have not felt justified in sending anything but food to our starving colleagues. One hundred and fifty-six physicians and eleven medical societies have thus far contributed to this fund. There are approximately 142,300 physicians in the United States. If each one would contribute even a small sum, it would be possible to supply the necessary food, drugs and clothing. Do not hesitate because your check is not as large as you would like it to be. Contributions of any amount will be welcome.

Every cent you give will be economically spent for supplies for Belgian physicians and their families. There are no charges for shipping and distribution.

Not a cent has been spent for stenographer, stationery, stamps, etc.

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BOOK REVIEWS

CLINICAL DIAGNOSIS AND URINALYSIS

By J. R. Arneill, Denver, Colo. Lea & Febinger, 2d Edition, 1914.

Arneill's Manual is the most useful and satisfactory little book on Laboratory Technique and Diagnosis that has come to our notice in recent years. The directions are so clear and concise that even the novice in the laboratory can follow them with ease.

The methods of obtaining and examining the gastric contents after the various test meals are fully given—with Topfer's method for the acids, the most prominent. The method of obtaining blood serum, and the technique of the various reactions is made plain so that a beginner could understand and perform the Widal test. The Wasserman test is fully explained, but not recommended except for the specially trained worker. The cytology of the cerebro-spinal fluid in the various diseases occupies a prominent place and is brought within the reach of every one. The examination of blood and blood films, and the important place given to the differential leucocyte count puts many a more pretentious book to shame.

In the examination of blood films we are surprised that the simple May Grunwald method of fixing and staining the specimen with one process by methyl alcohol-eosin-methylene blue should have been omitted, as it is the best general blood stain yet devised, and makes the very important differential count easy for the general practitioner.

Dr. Arneill's book should have a place on the laboratory work table of every physician who tries to give his patients the benefits of modern laboratory methods in diagnosis and prognosis. DETWEILER (Omaha).

LOCAL AND REGIONAL ANESTHESIA, INCLUDING ANALGESIA

By Carroll W. Allen, M. D., of Tulane University, New Orleans, With an Introduction by Rudolph Matas, M. D., of Tulane University, New Orleans. Octavo of 625 pages with 255 illustrations. Philadelphia and London: W. B. Saunders Company, 1914. Cloth, $6.00 net; half morocco, $7.50 net.

Starting with the history of anesthesia, the author has covered the subject thoroughly, approached it from every angle, sought the effect of local anesthesia in every ramification of innervation, distribution of sensation and philosophy of pain. The effect of pressure anesthesia, toxicology of drugs used, technic, indications, contra-indications, shock, anoci- association, intra-arterial anesthesia, general anesthesia through the intravenous injection of local anesthetics, are all discussed.

In addition the use of local anesthesia in special regions as genito-urinary tract, ano-rectal area, the neck, throat, gynecologic region, spinal analgesia and epidural injections, paravertebral, parasacral, the head, scalp, face, cranium and brain, the organs of special sense and dental anestehsia are taken up and systematically dealt with.

The author is painstaking and elaborate, yet presents his subject in a manner that shows certainty and precision. BARNHART (Omaha).

A TREATISE ON CLINICAL MEDICINE

By William Hanna Thomson, M. D., L.L. D., formerly professor of practice of medicine and of diseases of the nervous system in the New York Medical College; ex-president of the New York Academy of Medicine, etc. Octavo volume of 667 pages. Philadelphia and London: W. B. Saunders Company, 1914. Cloth, $5.00; half morocco, $6.50.

Thomson's work is in a class by itself. No author has the same easy style of writing and at the same time covers his subject in such an efficient and thorough manner. Each subject is taken up and discussed from the writer's own clinical experience and point of view.

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Part I, or the Introduction, consists of "Mechanism of Surface Chill, or Catching Cold," significance of common but important symptoms including pain, emaciation, cough, dyspnea, edema and vomiting; remedies, non-medical, medicinal, vaccines and sera.

Then follows a section devoted to the diseases of special tissues or organs, which deals at length with every subject that can be classified under this heading.

The book should be in every one's library and we take pleasure in recommending it to the medical profession. BARNHART (Omaha).

COLLECTED PAPERS

From the Research Laboratory of Parke, Davis & Co., Detroit, Mich., Vols. I and II.

These two volumes, the first published in 1913 and the second in 1914, represent a vast amount of valuable experimental work done in the Parke, Davis & Co. laboratories. The men engaged in this work are thoroughly trained chemists and pharmacologists, two of whom are personally well known and highly esteemed by the writer.

The character of the work outlined in these volumes is of a high order and has a direct practical bearing on many of the therapeutic problems of today. Many of the articles are well illustrated by graphic records, drawings or photographs of the results and conditions under discussion which increase greatly the value of the text.

The subjects treated are too many to be given in detail and besides there is a complete index to each volume. Some of the more important subjects of investigation are:

The Administration of Diphtheria Toxin in Collodion Sas.
Resistance of Smallpox Vaccine to Coal Tar Disinfectants.
An Investigation of the Depressant Action of Pituitary Extracts.
Serum Treatment of Hemorrhage and Blood Dyscrasias.
Pituitary Extracts in Obstetrics and Gynecology.
The Physiological Activity of Cannabis Sativa.
On the Cultivation of Treponema Pallidum (Spirochaeta Pallida).
Drug Influence on Extrasystoles of the Mammalian Heart.

These are only a few, but show the range of subjects investigated and the character of the work contained in these two volumes.

SURGICAL CLINICS OF JOHN B. MURPHY.
Vol. 3, No. 6

The December issue of the clinics contains a portrayal display of Dr. Murphy, some of the members of his staff and office equipment.

It appears that Dr. Murphy has given up his down town office and concentrated his offices and workshop in a specially constructed building located near the Mercy hospital. A plan of this kind has been adopted by the Mayos at Rochester, Minn.

Evidently team-work, the co-operation of a competent staff of specialists will be a future adaptation among many progressive and capable medical men. The introductory illustrations although, perhaps, too personal, should furnish no ground for critique, they are along the lines of progressive medicine and surgery.

Among some of the valuable statements in this issue—speaking of acute appendicitis, Dr. Murphy insists that all appendices should be taken out inside of the first 48 hours of the attack, if seen within that time and the diagnosis made. The most dangerous day on which to operate is the third or fourth, because at this time one so frequently finds an abscess without local coffer-damming. These cases require surgical judgment and a knowledge of the principles governing the situation. If you open the abdomen and find an abscess be happy to let the pus out, put in a liberal drain and apply absorbent dressings. The appendix can be safely removed four to six weeks later. WIGHTMAN (Omaha).

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WYOMING SECTION

WESTERN MEDICAL REVIEW

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Vol. XX. CHEYENNE, WYO., MARCH, 1915 No. 3

ABSTRACTS

Alleged Dangers to the Eye Disproved

In its issue of Oct. 17, The Journal of the American Medical Association comments on recent work of Verhoeff and Bell concerning the effects of various illuminants on the eye. As expressed by them, the vital question is not whether a light source gives ultra-violet radiations, but whether it gives them of such kind, and in sufficient quantity, as to make an injury to the eye possible under practical conditions. The findings of Verhoeff and Bell are expressed, broadly, by the statement that no artificial source of light used for illuminating purposes contains enough ultraviolet radiation to involve the slightest danger to the eye from its effects under any readily conceivable conditions of use, and that such pathologic action as can be obtained experimentally from the ultraviolet is confined to a strictly limited region of the spectrum and obeys perfectly definite quantitative laws in its action.

Regarding a number of alleged pathologic effects which have been charged up against radiation, Verhoeff and Bell have this to say: Eclipse blindness, the only thermic effect on the retina of common occurrence clinically, is due to the action of the concentrated heat on the pigment epithelium and choroid,

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this heat being almost wholly due to radiations of the visible spectrum, within which the maximum solar energy lies. Erythropsia is not in any way connected with the exposure of the eye to ultraviolet radiations, but is merely a special case of color fatigue temporary and without pathologic significance. In the case of vernal catarrh and senile cataract they can find no evidence for considering them as due to radiations of any kind. Glass blowers' cataract, often charged to specific radiation, ultraviolet or other, is regarded as probably due to the overheating of the eye as a whole with consequent disturbed nutrition of the lens.

It is comforting to be told that commercial illuminants are entirely free from danger under ordinary conditions of their use. The glass enclosing globes used in all practical commercial illuminants are amply sufficient to reduce any abiotic radiations very far below the danger point.

Induced Pneumothorax.

E. von Adelung, Oakland, Cal. (Journal A. M. A., June 20, 1914), reviews the history of artificial pneumothorax, described by Forlanini and Murphy, and describes the apparatus and technic. The manometer is the guide to the work. He gives his own experience. The benefits of the operation are not always apparent at first, and symptoms may become temporarily aggravated; but after a few weeks the good results appear, as physiologic rest has been obtained. Pain from the operation is sometimes unavoidable on account of the tension of lesions and the displacement of organs, but it is rarely of long duration and it is best minimized by gradual increase of pressure. Subcutaneous emphysema results from too much positive pressure. The spring pad hernia truss is often useful in alleviating it. Bleeding from the opposite lung is rare. Puncture of the lung is to be avoided, though it commonly causes little or no trouble. The most important accidents are pleural reflex and gas embolism, but only few deaths have been recorded. The distinction between the two is not clear, and some authors consider them to be identical. Clinically pleural reflex and gas embolism yield the same syndrome; fainting, pallor, convulsions, perhaps temporary or permanent paralysis and occasionally death. The Bauer incision seems to be, to some extent, a safeguard, and Saugman and some others aspirate before turning on the gas to see whether or not the needle is in a blood vessel. Von Adelung says: "My conviction is that air

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embolism and real pleural reflex, such as results experimentally from the injection of irritating fluids into the sac, are both to be avoided by using warm, moist nitrogen, careful local anesthesia of the pleura and proper observation of the manometer. Not until the latter records free oscillations with persisten negative mean pressure can one feel sure that gas may be introduced safely, unless one is using the open method." There is much difference as regards cases appropriate for induced pneumothorax. Hemoptysis is controlled by the method and high temperature is not a contra-indication. Natural pleural effusion acts the same way, but a small one may be aided by adding gas, thus inducing more complete lung rest. All writers agree that laryngeal tuberculosis is not a bar to the treatment. Pleuritic adhesions, if extensive, are a serious mechanical hindrance to the method. If slight, they may be broken down by gas pressure, if carefully applied, and perhaps sufficient free pleura may permit its use. If the patient is already dyspneic, unless it be due to a toxin, pneumothorax is irrational. Miliary tuberculosis is regarded as a contra-indication, and so are serious cardiac disorders and marked splanchnoptosis. The main discussion is on how early artificial pneumothorax should be performed. Most writers advise it only in moderately advanced unilateral cases, but Von Adelung thinks that careful study of the individual case should be advised. He follows Murphy in advising it in cases in which there is no absolute contra-indication, and says that when it does not cure it often alleviates. He says: "My experience is limited to forty-two cases, all but one bilateral and well advanced. All but one were ambulant, the patients coming to the office for treatments. Of the forty-two cases it is noteworthy that pleuritic adhesions prohibited pneumothorax in only five. The total number of punctures done was over 614, and no gas embolism occurred; but pleuritic effusion supervened in six cases, one being purulent. Twenty-two patients gained weight and eleven lost weight, this observation being unrecorded in four cases. In thirty-seven cases in which a pneumothorax, even though small, was possible, twenty-eight patients were improved in varying degrees, one case was arrested (perhaps cured) and ten remained unimproved."

When you have a rapid heart and an increasing nervousness, do not pass it lightly by as a "nervous-heart case." Look carefully for other signs and symptoms of hyperthyroidism such as tremors, dyspnea and ophthalmos.

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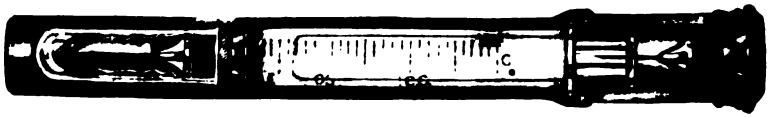

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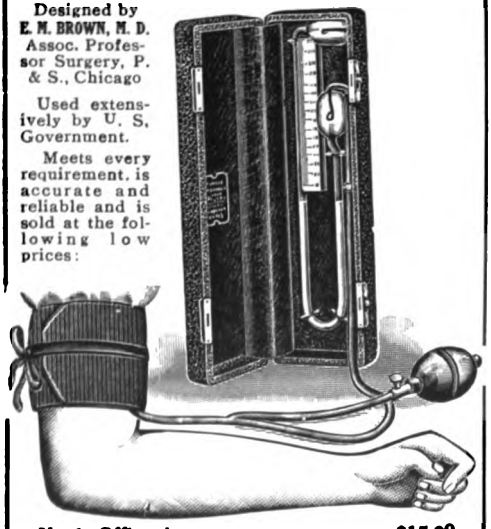

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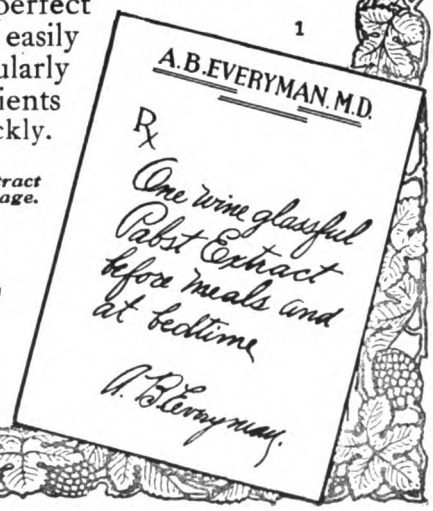

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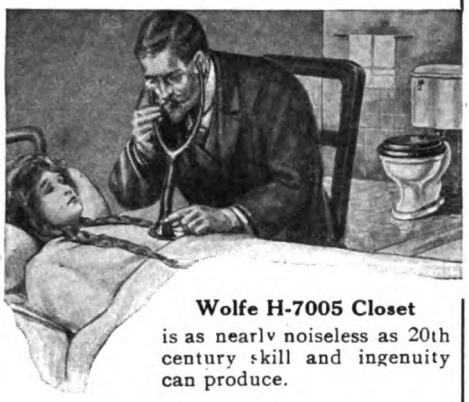

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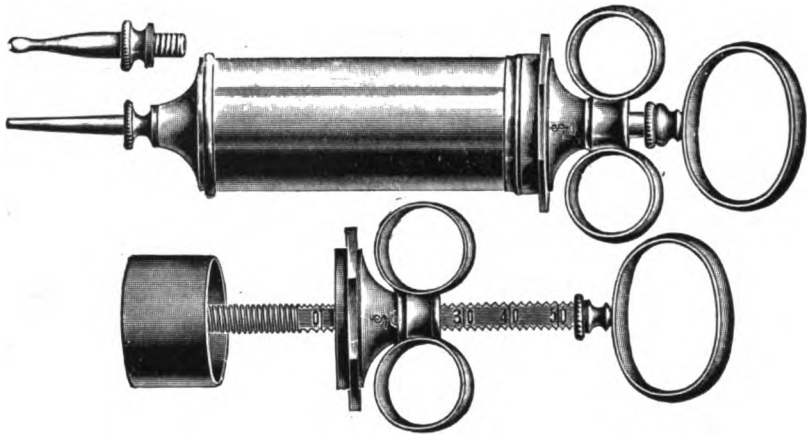

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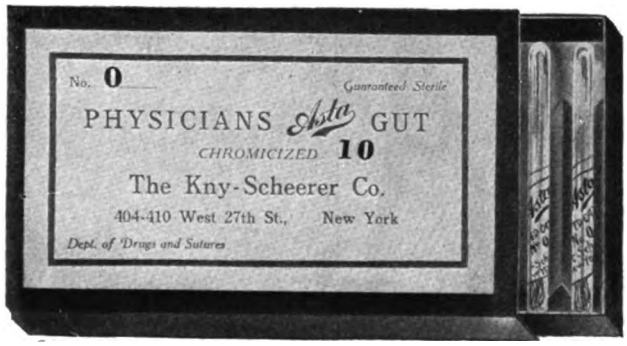

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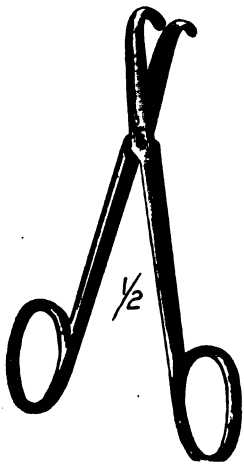

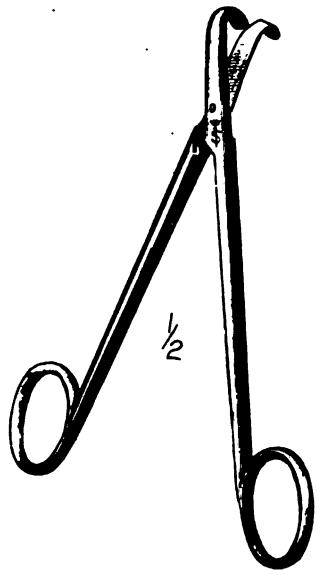

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in using Blunk's Pressure Forceps, that the following points are of importance:

(1) The veins should always as far as possible be grasped in a transverse direction.

(2) The inclusion of surrounding tissue in the grasp of the forceps is no disadvantage, but on the contrary increases the efficacy of the haemostatic process.

(3) The pressure forceps should be closed and opened slowly.

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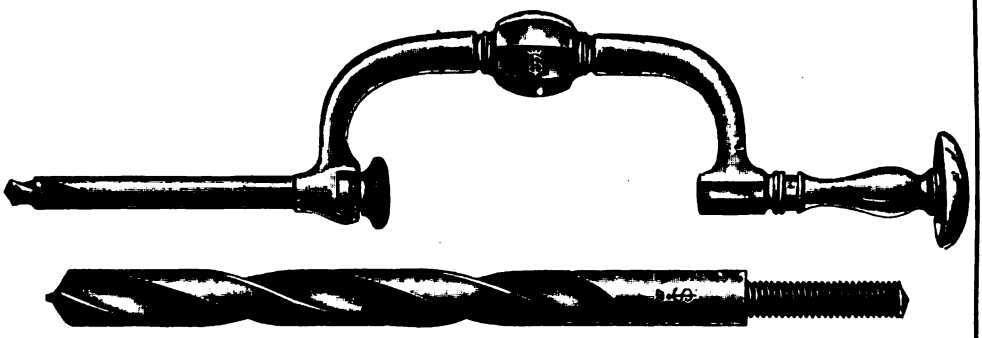
Carr's Cranial Bone Drill

A Most Useful Instrument
In Brain Surgery



Carr's cranial bone drill or trephine is used for making an osteoplastic flap of the skull in brain surgery. By means of the drill several holes are made, to be afterward connected by cutting away the intervening spaces with the rongeur forceps or a Gigli wire saw. The drill cuts a hole five-sixtenths inch in diameter very rapidly and safely. It is furnished with a guard by which the depth of the cut can be regulated, obviating all danger of cutting into the dura.

This instrument has several advantages over other instruments for opening the skull. It cuts more easily and quickly—requiring less pres- rongeur forceps, which is all that is needed. Three or four holes can be bored in a triangle or square and connected in a few minutes, or a large osteoplastic flap made in the same way.

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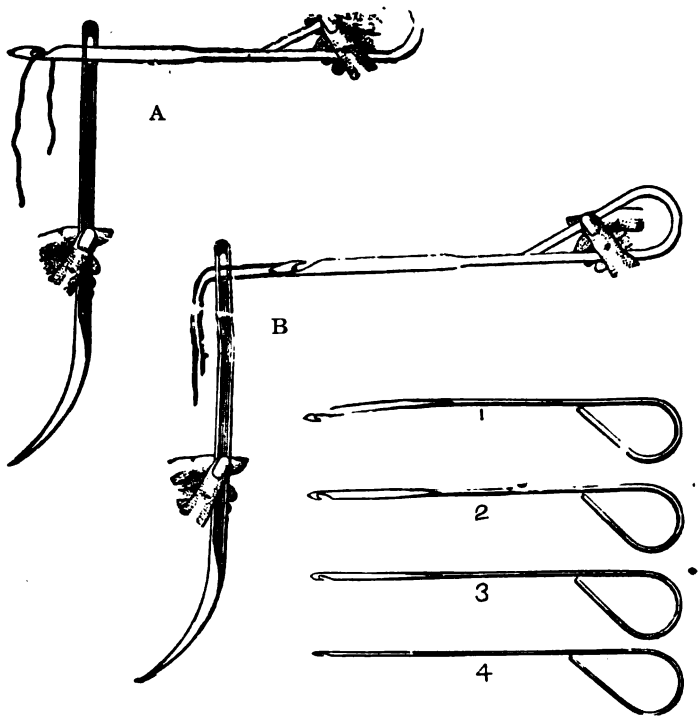

Pass the hook of the threader through the eye of the needle, as shown in Illustration A. Grasp the suture with hook end and pull gently back (B). The threaded needle is then ready for use. Threaders can be sterilized together with surgeons' needles.

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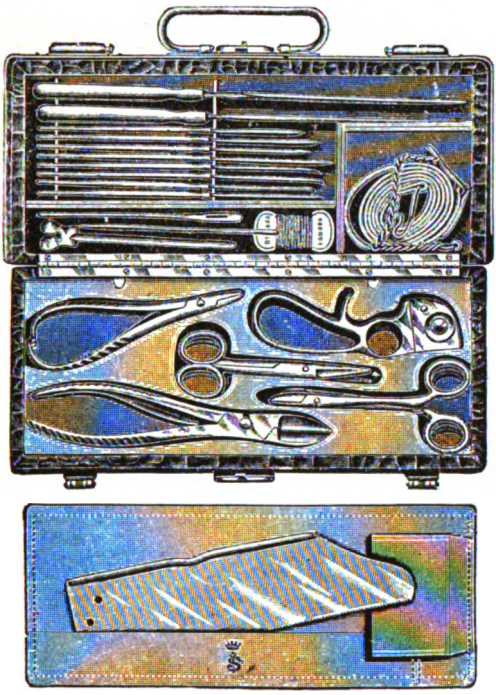

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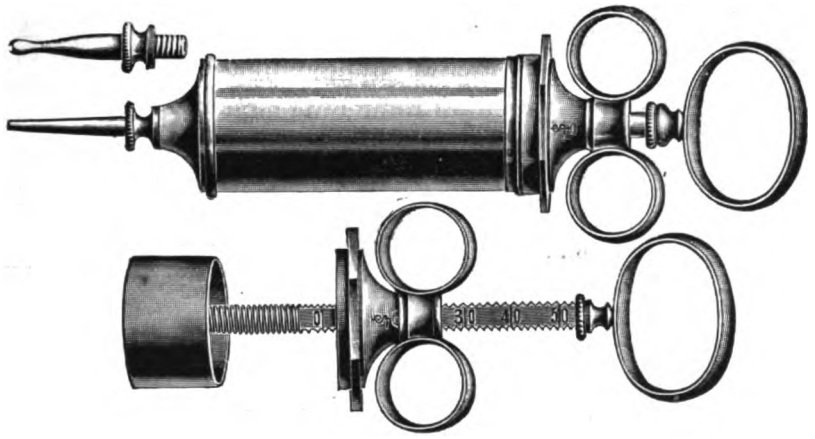

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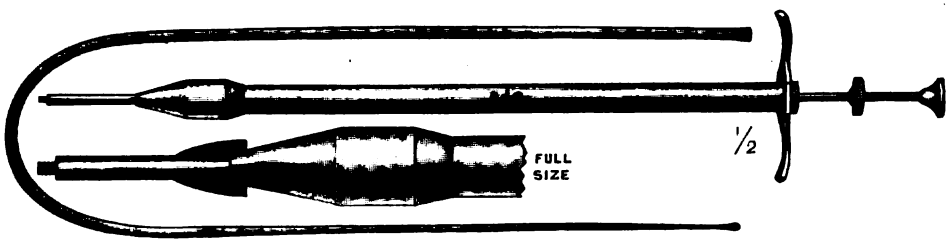

BREDIN'S NEW URETHROTOME, half size, with end actual size and showing knives: surrounded by a filiform catheter. A set screw operated by the thumb sets free the knives

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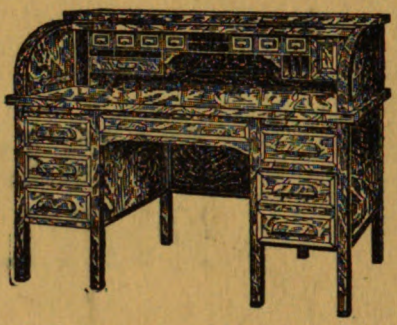

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